The Journal

of the Michigan State Medical Society

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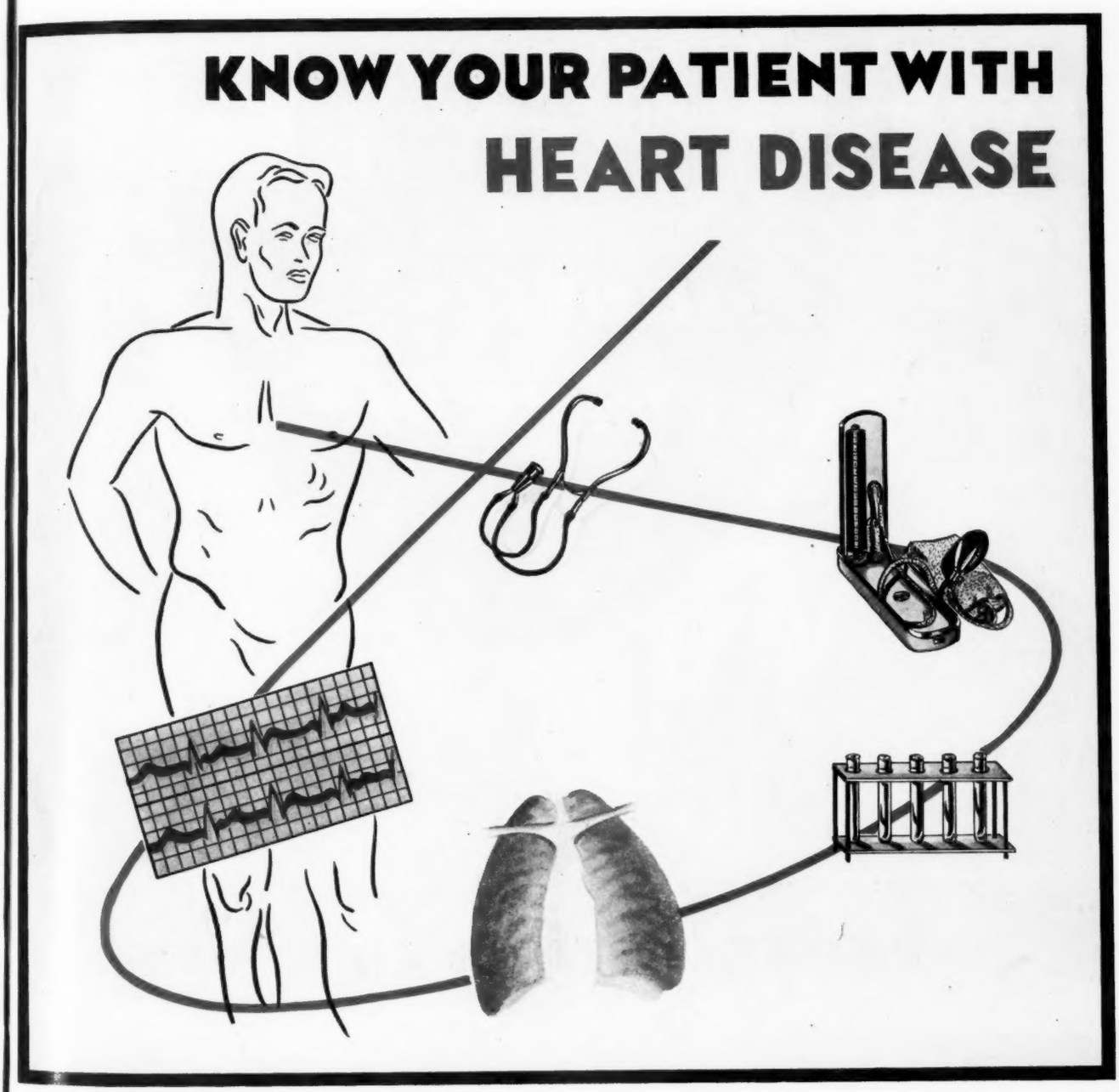


You and Your Business

HIGHLIGHTS OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of October 19, 1949

- Monthly financial reports, including detailed breakdown of the Public Education Account and of the Public Education Reserve Account, were presented, studied, discussed and approved. Bills payable for the current month were presented and approved.
- The osteopaths' request to be entitled, *legally,* to render service to afflicted and crippled children under Michigan's two acts authorizing medical service to these wards of the State: A report on the osteopaths' petition to the Legislative Committee on Administrative Rules, at its October 5, 1949, meeting, requesting such a change in the rules and regulations of the Michigan Crippled Children Commission, was reported. After a full day of arguments, presented by the Michigan Association of Osteopathic Physicians and Surgeons and its Legal Counsel, the Legislative Committee on Administrative Rules decided that it had no jurisdiction in the matter and referred the osteopaths to the Legislature of 1951.
- Two representatives of the Michigan State Medical Society to the Medical Care Section of the American Public Health Association (meeting in New York, week of October 24) were appointed.
- The Standing and Special Committees of The Council for the year 1949-50 were appointed by Chairman O. O. Beck, M.D.
- Committee reports were accepted from the Advisory Committee on Hearing Conservation; the Tuberculosis Control Committee jointly with the County Societies Committee of The Council; and from the Medical Director of the Michigan Rheumatic Fever Control Program (Leon DeVel, M.D.).
- Fee schedules in Michigan's counties for medical care of welfare patients: An analysis of these schedules was presented to the Executive Committee of The Council which instructed that the information be forwarded to all county medical societies via the next Secretary's Letter. The value of Filter Boards, to save finances for the counties, was stressed.
- Public meetings on various scientific subjects (such as heart, rheumatic fever, diabetes, etc.) were authorized, to be organized through the MSMS Public Relations Department, with the co-operation of all special societies interested in control of these various diseases.
- Tentative program for the Annual County Secretaries-Public Relations Conference of January 22, 1950, Book-Cadillac Hotel, Detroit, was discussed. The theme of the meeting will be "Americanism."
- Group practice study—a request from the AMA for information on the subject of group practice throughout the State of Michigan was referred to the various Councilors of the State Society, for action.
- March, 1950, Michigan Postgraduate Clinical Institute: J. J. Lightbody, M.D., Detroit, was appointed as Chairman of the Wayne County Hospitality Committee; E. C. Texter, M.D., Detroit, was appointed as Chairman of the Committee on Hotels; and R. A. Johnson, M.D., Detroit, Chairman; J. S. DeTar, M.D., Milan; H. F. Dibble, M.D., Detroit; and S. W. Donaldson, M.D., Ann Arbor, were appointed to the Press Relations Committee.
- Scrolls were authorized to be presented on March 10, 1950 (during the Postgraduate Institute) to F. A. Coller, M.D., Ann Arbor, as President of the American College of Surgeons and to A. H. Whitaker, M.D., Detroit, as President of the American Association of Industrial Physicians and Surgeons.
- Organization of state medical society legal counsels. This recommendation of Legal Counsel J. Joseph Herbert was approved by the Executive Committee of The Council. Mr. Herbert was authorized to proceed with a plan to organize the legal counsels of the various state

(Continued on Page 1434)

EXECUTIVE MEETING OF THE COUNCIL

(Continued from Page 1432)

medical societies in co-operation with the Legal Department of the AMA.

- FBI investigation of medical societies. The Executive Committee of The Council instructed that information on this subject be published in the next CAP Bulletin—and the recommendation that MSMS members read the AMA release on this subject (JAMA, Page 465, October 15, 1949).
- The Public Relations Counsel's progress report included a list of District CAP meetings (the first being held in Kalamazoo on October 13); shift of the areas for the Public Relations Field Secretaries was authorized; approval was given to a distribution plan for the MSMS movie "To Your Health" to be made to out-of-state organizations. Report on the progress of the Woman's Auxiliary with its many public relations projects (including distribution of the pamphlet "It's No Bargain") was presented; the basis for a contract of syndication of the MSMS radio program "Tell Me, Doctor" has been arrived at and a contract is being drawn. A large attendance is expected at the 1949 Rural Health Conference scheduled for Grand Rapids October 28-29.
- The meeting was adjourned with thanks to Drs. Frank Van Schoick of Jackson and Dr. John Van Schoick of Hanover for their hospitality on this occasion.

OPD AT UNIVERSITY OF MICHIGAN HOSPITAL

University Hospital at Ann Arbor has furnished the following practical information, relative to the functioning of its Out-Patient Department, with the hope that it will be better able to supply streamlined service to Michigan doctors of medicine and to their patients:

1. *Consultant Service.*—The University Hospital functions as a consulting service. Except in emergencies, patients are seen only when referred by a physician. Referral may be done in person, by telephone, or by letter, the latter being preferred. It is requested that referral letters contain sufficient clinical information to aid in assigning the patients to the appropriate clinic or clinics. Your suggestions regarding specific diagnostic procedures that may be required will be most helpful.

All patients below the age of 14 are automatically registered in the Pediatrics Department, after which they may be referred to other specialized clinics.

2. *Clinic Hours.*—Monday through Friday, 8:00 A.M to 12:00 noon; 1:00 P.M. to 5:00 P.M. Clinics are closed on Saturday, Sunday, and Holidays. (Holidays observed include Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day, and New Year's Day.)

3. *Registration.*—Patients are requested to arrive at least one hour in advance of the time of their appointments in order to register. This procedure includes 70 mm. chest photofluorogram, standard blood Kahn test, and hemoglobin determination. A single registration is valid for one year.

4. *Appointments for examination.*—

Clinics requiring appointments

Dermatology
Gynecology
Medicine, including:
- Allergy
- Endocrinology & Metabolism
- General Internal Medicine
- Heart Station
- Medical Tuberculosis
- Simpson Memorial Institute for Blood Diseases

Neurology
Neuropsychiatry
Obstetrics
Ophthalmology
Otorhinolaryngology
Pediatrics & Communicable Disease
Thoracic Surgery
Veterans Readjustment Center

Clinics not requiring appointments

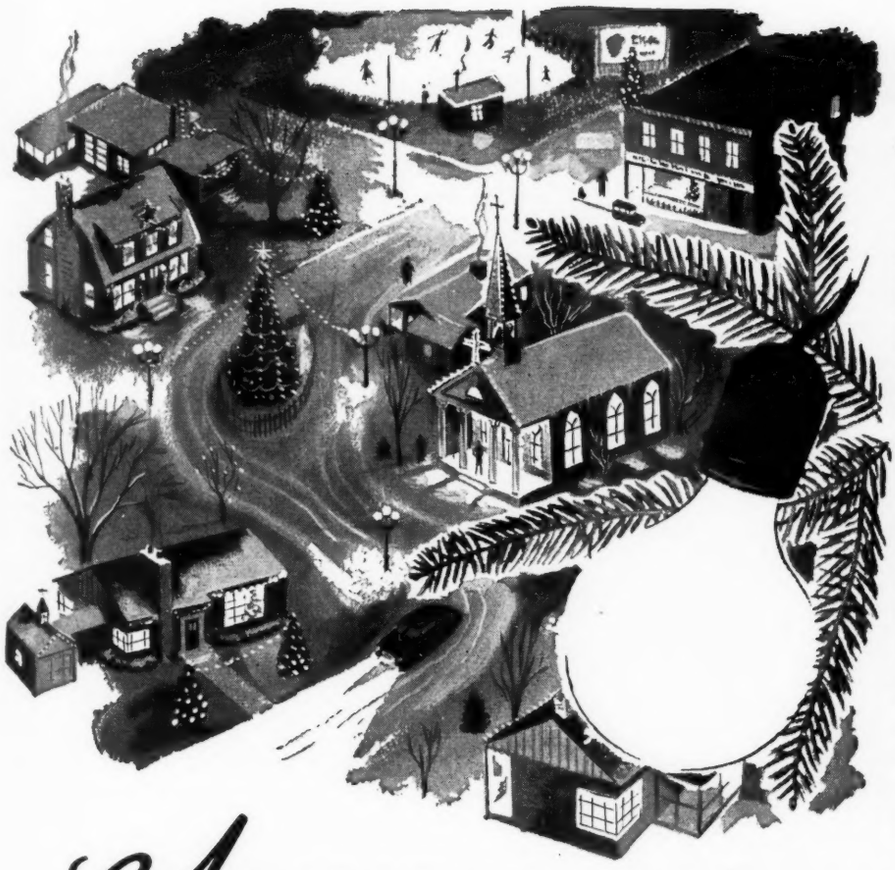
General Surgery
Oral Surgery
Orthopedic Surgery
Neurosurgery
Urology

If you feel that your patient will require special diagnostic or therapeutic radiology, electroencephalography, or any other highly technical procedure, arrangements for these can be made in advance.

5. *Cost to Patient.*—An initial flat-rate payment for registration and clinic fees is made at the time of registration. The amount of this payment covers professional clinic fees for a period of fifteen days from the date of registration, regardless of the number of visits to a single clinic or the number of clinics visited. It does not include fees for special laboratory tests, x-ray examinations, minor surgical procedures, etc. These are paid at the time the service is rendered.

After the expiration of the fifteen-day period,

(Continued on Page 1436)



44

of NEMBUTAL'S CLINICAL USES

SEDATIVE
Cardiovascular
Hypertension
Coronary disease
Angina
Decompensation
Peripheral vascular disease

Endocrine Disturbances
Hyperthyroid
Menopause

Nausea and Vomiting
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm
Pylorospasm
Spasm of biliary tract
Spasm of colon
Peptic ulcer
Colitis
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.

Irritability Associated With Infections

Restlessness and Irritability With Pain

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

OBSTETRICAL
Nausea and Vomiting
Eclampsia
Amnesia

HYPNOTIC
Induction of Sleep

SURGICAL
Preoperative Sedation
Basal Anesthesia
Postoperative Sedation

PEDIATRIC
Sedation for:
Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

Preoperative Sedation

Adapted to a variety of uses

Another product adapted to a variety of uses is short-acting Nembutal. Clinical reports now numbering more than 500 review over 44 conditions in which it is being effectively used. See list at right.

Adjusted doses of short-acting Nembutal can provide any degree of cerebral depression—from mild sedation to deep hypnosis. Dosage required is only about *one-half* that of many other barbiturates. Small dosage has several advantages: less drug to be inactivated, less possibility of "hangover," shorter duration of effect, greater safety and definite economy to the patient.

Short-acting Nembutal is available as Nembutal sodium, Nembutal calcium and Nembutal Elixir, all in easily administered small-dosage sizes. For the tab-indexed booklet, "44 Clinical Uses for Nembutal," write to ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS.

In equal oral doses, no other barbiturate combines

QUICKER, BRIEFER,

MORE PROFOUND EFFECT than . . . *Nembutal*®

(Pentobarbital, Abbott)

OPD AT UNIVERSITY OF MICHIGAN HOSPITAL

(Continued from Page 1434)

the patient pays a return visit fee for each clinic visit.

When patients are unable to bear the expense of care, adults should be referred to the local social welfare department, children's parents to the probate court.

6. *When hospitalization is considered necessary* by the clinic physicians, your patient will be asked to make an initial deposit, based upon the estimated length of stay and anticipated treatment required. He should bring evidence of any hospitalization insurance he carries covering in-patient or out-patient services. With this, we shall be in a position to secure confirmation from his insurance company immediately and thereby assist him in collecting disability and hospitalization benefits without delay.

If you indicate in your referral letter that your patient may require hospitalization, every effort will be made to insure a tentative bed appointment for him.

7. *Reports.*—A report of clinical findings and recommendations will be sent to you after complete examination of your patient. These reports are forwarded after all consultations and diagnostic procedures are completed. Every effort will be made to forward reports as expeditiously as possible.

8. We appreciate your cooperation and will welcome any comments or suggestions that will further the best interests of your patients and improve our service to you.

APPOINTMENT OF SCIENTISTS (Psychologists) IN THE USPHS

A competitive examination for appointment of Scientists (Psychologists) in the Regular Corps of the United States Public Health Service will be held on March 20, 21, and 22, 1950. Applications must be received *no later than February 20, 1950.*

The Regular Corps is a commissioned officer corps composed of members of the various medical and scientific professions, appointed in appropriate professional categories such as medicine, dentistry, engineering, the sciences, etc. Psychologists are included in the Scientists category of the Service.

Appointments will be made in the grades of Assistant Scientist (equivalent to Army rank of First Lieutenant) and Senior Assistant Scientist (equivalent to Captain). Appointments are permanent in nature and provide an opportunity for qualified psychologists to pursue their profession as a life career in the Service. While all commissioned officers are subject to change of station and assignment as necessitated by the needs of the Service, consideration is given to the officer's preference, ability, and experience. The coming examinations will be primarily for clinical psychologists, broadly defined, and successful applicants will be assigned to positions involving research, diagnosis, and therapy. Positions in clinics, hospitals, penal institutions, research programs, and administrative work may be available.

NEW AUSTERITY BUDGET TO MAKE PATIENTS PAY AS COSTS SOAR IN BILLIONS

London, October 19—Britain is being forced into a drastic revision of the system of free socialized medicine as a part of an impending budget slash. . . . But the shock which may hit the public most heavily—more sharply even than prospective higher prices without wage increases—will be the abandonment of the free features of socialized medicine.

This socialized medicine program is the most popular reform in postwar Britain and both parties claim credit for it. The Tories say they started it and the Socialists merely carried out their program. It is, of course, labor's baby. Neither party would dare abolish it.

But the medical program costs vastly more than was expected.

Britons can get free medicines, dentures, toupees, glasses—sometimes two or three pairs. Also a person with a hangover can get free morning-after aspirin by getting a chit from the doctor.

Hypochondriacs pile up waiting lines, and also costs, while telling doctors their ills.

It now develops all this has not been free. When the national health bill was introduced the estimate of the first year's cost from general taxes, beyond worker-employer contributions, was £95,000,000—$2,660,000,000 at the devalued rate of exchange. Later estimates raised this to £150,000,000 ($4,200,000,000) for nine months.

In February, 1949, after the system had been operating for seven months, this estimate was boosted to £203,000,000 ($5,648,000,000) for nine months.

For the current year the estimated total cost of the system from general taxes plus contributions is estimated by officials at £352,000,000 ($9,856,000,000).

Any politician who tried to wipe out the system would run the risk of being wiped out of office, personally, by voters who have their first glasses and dentures in their lives. But if costs of this kind are not stopped, top cabinet economists are conceding that inflation will dissipate the advantage of devaluation.

So henceforth there is likely to be a specific charge on nearly all services, or a weekly health deduction from pay envelopes, up sharply enough for the patients to know that the service is not free, and perhaps then people will start policing each other's free riding.

To the British public, still largely innocent of understanding what a dollar-jam their country is in, this will go down roughly.

Attlee and Cripps, with an election in the spring, hope to call on a Dunkerque spirit, saying it may be bad politics but the country needs it.

If the proposed cutbacks are skillfully managed, the Conservatives may support much of the program.—*Detroit News,* Oct. 19, 1949.

much to recommend it

SOLGANAL*

(aurothioglucose)

Schering's aurothioglucose has much to recommend it for the treatment of active rheumatoid arthritis. Water soluble, but suspended in oil to provide prolonged absorption, it is effective in small dosage, frequently inducing remissions in early acute phases of the disorder.

in active rheumatoid arthritis

Marked improvement has been reported in "50 to 60 per cent of patients, moderate improvement in 20 to 25 per cent. . . ."[1] Among 1000 patients treated recently with SOLGANAL, there were no fatalities and few instances of severe toxicity.[1]

1. Rawls, W. B.: New York Med. (no. 15) 3:19, 1947.

*®

SOLGANAL

Schering

CORPORATION · BLOOMFIELD, N. J.

Michigan Rural Health Conference

R. J. Hubbell, M.D.

The Third Annual Michigan Rural Health Conference is history.

Any recording of the two-day event held in Grand Rapids, October 28-29, will of necessity have to state that the meeting, which is used as a model for similar gatherings throughout the nation, was an unqualified success.

Part of the credit for the 1949 Conference, which established a new registration figure of 507, is due to the year-round efforts of the Committee on Rural Medical Care of the Michigan State Medical Society headed by Councilor R. J. Hubbell, M.D., Kalamazoo. Dr. Hubbell met several times as a member of the Committee on Arrangements and during the Conference served as Chairman of the Committee on Resolutions. Commenting on this year's meeting, Dr. Hubbell said:

"The comments of those in attendance indicate that the conference carried on and amplified the work of previous years in determining rural health needs and ways to meet them. From the seeds of knowledge which were planted in the minds of rural leaders, we feel certain that many tangible results will be forthcoming. The assemblage benefited greatly from the national speakers who keynoted the program. Opportunity was provided for expression of the thinking of people from small rural communities through several open discussion periods. The Michigan Foundation for Medical and Health Education and the other fifty-two co-sponsors deserve unqualified congratulations for this splendid meeting. Special praise goes to Chairman E. I. Carr, M.D., Lansing, and Executive Secretary E. H. Wiard, Lansing, for their expert handling of the details of this year's meeting."

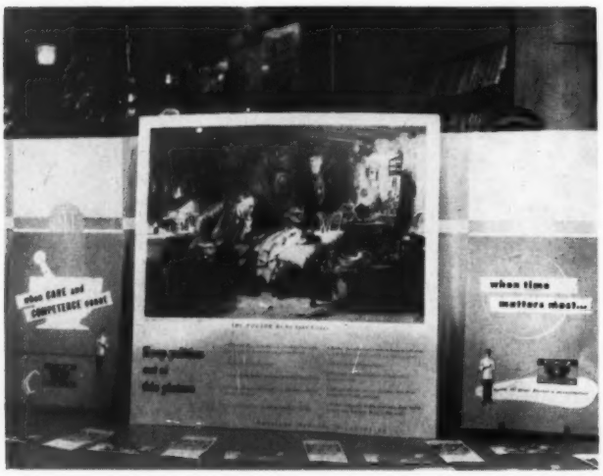
The 1949 Conference emphasized open discussion. Persons from ten geographical areas, comprising every county in Michigan, talked on the health problems in their own areas. From these small groups the participants went into four larger assemblies where the subjects "Obtaining and Retaining an M.D. in a Rural Area," "Community Health Education," "Rural Public Health" and "Medical Care Facilities" were discussed.

Outstanding personalities on the program included Dr. J. O. Christianson, Minneapolis Superintendent of the School of Agriculture, University of Minnesota, Mrs. Charles Sewell, Chicago, Administrative Director, Associated Women of the American Farm Bureau Federation; Prof. Paul D. Bagwell, East Lansing, Past President, United States Junior Chamber of Commerce; and J. S. DeTar, M.D., Milan Councilor MSMS.

RESOLUTIONS ADOPTED

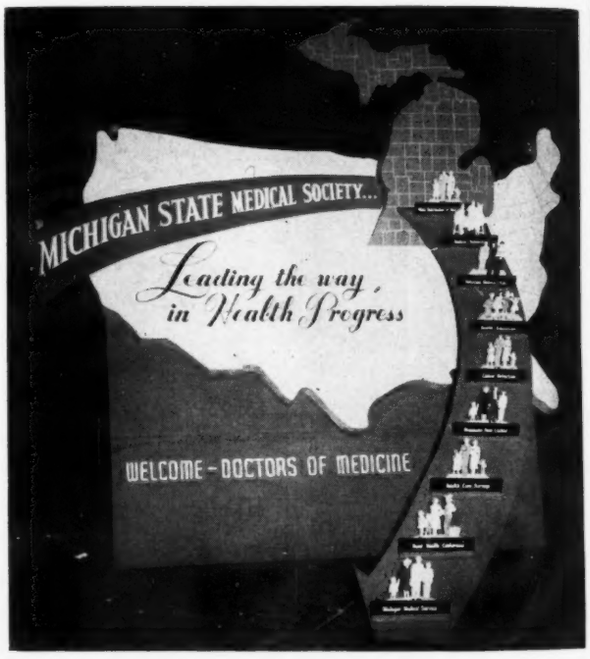
1. That discussion pertaining to health personnel problems of a combined lay and professional character in a community should be initiated principally by lay groups, preferably through the medium of a County Health Council.
   That the local and state co-sponsoring groups explore the important question of making living, social and financial conditions of a nature to attract young medical practitioners and especially those with families, to locate in rural communities.
2. That Community Health education be implemented by training of persons in the mechanics of accomplishment of these objectives.
3. That the obtaining of local health departments is best achieved by cooperation between interested local groups and boards of supervisors.
4. That the Office of Hospital Survey and Construction give highest priority in its future construction plans to public health and medical care centers in isolated rural communities in order to attract physicians to such communities.
   That greater emphasis be placed by the Office of Hospital Survey and Construction upon the widest possible distribution of information concerning the hospital and health center construction program under Public Law 725.
   That the education of nurses, medical technologists, physical and occupational therapists and dietitians is primarily a responsibility of the public schools, colleges and universities which should set the standards and assume the major financial responsibility.
   That the hospitals and health centers in every community be utilized to the fullest possible extent in such an educational program to make educational opportunities conveniently available to everyone.
5. That a meeting of all co-sponsors of this Conference be called by the presiding chairman of the Conference at the earliest reasonable date following this meeting—not later than January 31, 1950, for the purpose of determining upon a place and date and a Committee on Arrangements for the Fourth Annual Michigan Rural Health Conference to be held in 1950.

PR In Practice



AT FAIRS AND CONVENTIONS—Attractive, colorful displays of the type pictured at the right have been used with great success throughout the state. This particular display was developed by the Michigan State Medical Society and has been used in store windows, at conventions, and at county fairs. Typical of the use was by the Jackson County Medical Society during the period of the Jackson County Fair last summer. Another utilization was when it occupied one of the larger display windows of Wurzburg's, a Grand Rapids department store. At conventions or meetings it can attract attention to the work of the medical profession in much the same way as was done at the recent MSMS Annual Session.

IN DRUG STORES—The use of drug store windows as a medium for telling the story of voluntary medicine is strikingly illustrated at the left by the window display of the Garland Pharmacy in Traverse City, Michigan. The window was one of a large number placed by druggists of this city after a meeting held with the medical society, druggists, lawyers, insurance men and others in which the friends of medicine asked what part they could take in the campaign. The picture illustrates one way the druggists cooperated.



IN BANK LOBBIES OR WINDOWS—The Security National Bank of Battle Creek in cooperation with the Calhoun County Medical Society acquainted residents of that city in the national education program of the medical profession through the attractive lobby window display shown at the left. Bank President Horace F. Conklin is shown examining the window which plays up the large poster of "The Doctor." This is another excellent example of the co-operation that is being shown throughout Michigan and the nation by professions and organizations interested in keeping Americanism in America.

HOSPITAL BULLETIN BOARDS—An outstanding job to implement further the information available to doctors of medicine throughout Michigan is the photo at the right. It was taken in the Woman's Hospital of Detroit and is the work of one of the State's outstanding CAP workers, Roy C. Kingswood, M.D., Detroit. Dr. Kingswood and his Committee have established Bulletin Boards in most of Detroit's hospitals upon which items of particular interest to doctors are placed. Excellent photostated material from various newspapers and magazines has been supplied for Hospital Bulletin boards by R. L. Novy, M.D., Detroit. In addition, the Wayne County CAP Committee publishes a weekly mimeographed "CAP Bulletin" which occupies a prominent place on the bulletin board. Comments from busy physicians in the Detroit area indicate that this is a most unusual, yet extremely effective, approach to the problem of keeping individual doctors of medicine informed.

THE USE OF MEDIA—DISPLAY

The Public Relations office this month is instituting the first of a series of articles illustrating the practical application of the various forms of media that can be utilized in forwarding the medical public relations program of the MSMS.

The initial series serves to show in what ways visual mediums (other than motion pictures, sound strip films and slides) can be used by county medical societies throughout Michigan.

In following months, the articles will treat the use of radio, newspapers, magazines, pamphlets, motion pictures. The series will try to present through actual examples how various groups are making use of communication media open to them.

The examples pictured on the opposite page are typical of the methods being employed at the present time. While the use of displays and exhibits is only one of the media which can be employed, it should be pointed out that this is a most effective device for attracting a maximum audience at a minimal cost.

Window displays are employed in the same way that retail stores use them. They become silent allies of the profession; regardless of the time of day, they still remain at work. Unlike speakers and demonstrators, they never become tired and the message they portray is always present for the eye to pick up.

Displays may take several forms but the thought and preparation going into the exhibit are as important as any part of the physical shape. Color, design, motion and location are all important. With proper consideration given to these factors, the finished display should reflect an increased interest on the part of those who see it.

Various devices can be used to estimate the play and appeal gained from the time and money spent in preparation. Most popular and perhaps least troublesome is that of offering a sample, pamphlet or gadget to the "window shopper." In this way you can gauge, from items distributed, the interest that the booth or window gained.

FROM THE PUBLIC RELATIONS MAILBAG

"I think your efforts in the public relations field are top notch, and though I hate to admit it, I find myself looking across the lake to see what is going on."

E. R. THAYER, State Medical Society of Wisconsin

* * *

"I am glad to see that you are going to dig into this matter (H.R. 6000). MICHIGAN is always 'way out front. The danger is much greater than most persons realize."

MARJORIE SHEARON
Shearon Medical Legislative Service

(Continued on Page 1444)

Michigan Medical Service

VETERANS HOMETOWN CARE PROGRAM—SUGGESTIONS

Your attention is invited to the insert that is attached to the treatment reports currently being sent out for services to be rendered through the Veterans Hometown Care Program. The insert reads as follows:

> ATTENTION DOCTOR:
>
> May we ask for your cooperation in returning the attached papers promptly to comply with the Veterans Administration regulation as stated below:
>
> "If the veteran fails to report, or if service is not furnished during the authorized period, the issuing office must be notified to that effect, and all papers returned. If neither the papers nor the notification referred to above is received by the issuing office within thirty days after the expiration of the authorization, the authorization will be cancelled automatically."

The delay in sending in reports increases the administrative function of Michigan Medical Service as well as that of the Veterans Administration. It should be explained that funds for treatment and examination are set up by the Veterans Administration on a quarterly period based on an estimate of the previous quarterly expenditures. If reports are held up by the doctor, it becomes a difficult task to properly estimate these funds. In order to comply with the above quoted regulation, unreported claims must be cancelled if they are not received within thirty days after the expiration of the authorization.

When a report comes in after the cancellation has been effected in the offices of Michigan Medical Service, it becomes necessary to go through a considerable amount of additional paper work to reinstate the authorization. This can be obviated if the doctors will report the services rendered promptly, and it is equally important that authorizations for services not used, be returned after the expiration of the authorization period.

In the last case mentioned where the service was not rendered, it will be very helpful if the doctor will so indicate on the form before returning it. Frequently, claims or inquiries requesting reimbursement are received even after the form has been returned to Michigan Medical Service containing no information whatsoever indicating that treatments have been given the veteran. It is important that the papers be held by the physician until it is definitely known that the veteran will not require treatment during the authorized period. Likewise, it is equally as important to include all the dates of treatment on the form before returning it to Michigan Medical Service for payment. Once a report has been processed for payment on the strength of the information contained thereon, previously unreported treatment dates cannot be added to it.

When **Requests to Continue Treatment** forms are being prepared by the doctors office staff, every effort should be made to complete the form in its entirety. The items most commonly overlooked or omitted, causing unnecessary delay in the preparation of the authorization, are:

1. The code number for the type of treatment to be given.
2. The month during which treatment is to be given.
3. The condition for which veteran is to be treated.

(Continued on Page 1444)

MICHIGAL MEDICAL SERVICE—STATISTICS

Number of Subscribers, September 30, 1949 1,455,512
Number of Participating Doctors of Medicine 4,514
Number of Services Paid—Medical-Surgical Plans:

	1949	*Inception to 9/30/49*
	205,827	893,249

Amounts Paid for Services:

	1949	*Inception to 9/30/49*
Veterans Plans	$ 891,833.53	$ 3,431,595.28
Medical-Surgical Plans	7,077,892.08	36,964,141.54
Totals	$7,969,725.61	$40,395,736.82

Folic Acid

Folic acid, in either free or conjugated form, is a normal constituent of the tissues of the body and is usually present in the gastrointestinal tract. Not only are the glossitis and enteritis of sprue dramatically relieved by folic acid but the blood picture is also simultaneously improved. *Lederle* has been extremely active in conducting research in the field of nutrition, both in animals and man, and it is anticipated that the orientation of folic acid with respect to a number of other nutritional factors – including the anti-pernicious anemia factor and the animal protein factor – will soon be made clear.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

VETERANS HOMETOWN CARE PROGRAM

(Continued from Page 1442)

Requests should be submitted within sufficient time to allow for the preparation of the authority for the next period and it is recommended that the **Request to Continue Treatment** be prepared and sent to the Veterans Administration at least seven days prior to the expiration of the current authorization period.

MICHIGAN MEDICAL SERVICE REPORT

The report of July 31, 1949, shows Michigan Medical Service has 1,440,353 persons covered in its policies. This is still the largest group in the world even though a celebration was held in New York recently marking the assumption that that position was held by the United Medical Service of the New York area. Michigan, however, cannot hope to long occupy the foremost position because we haven't the population. We have between five and six million people to draw from whereas New York City alone has about eight million and the immediate surrounding counties which make up the area of the United Medical Service probably have another two million. In the nature of things, the United Medical Service must go ahead of us in numbers. There is a difference of 3,000 now. Michigan Hospital Service has 1,650,000 subscribers, still a little over 200,000 more than the medical service. The combined subscribers of Medical-Hospital-Surgical policies are now 65,540. It is interesting that during August, 1949, Michigan Medical Service paid the doctors for four cases where the service was rendered in 1943. The bills had never been rendered. Any other insurance company would have ignored those accounts, but Michigan Medical Service is anxious and willing to pay for the service as rendered to its certificate holders.

It has been noticed that income tax dates influence the rendering of bills and reports to Michigan Medical Service. Many times bills for November and December services are held over until January so that the receipts will be in the succeeding year. This trick eases up on the income returns for the doctor but throws the machinery of the Michigan Medical Service out of gear. Years of experience have shown that cases reported within thirty, sixty, and ninety days after services are rendered have a direct percentage bearing upon the total number of services rendered in any one month, but the experience this year shows that our formula is all out of line. For the middle months of this year, unusually large numbers of services have been reported, which is out of all proportion to our experience to the past several years. Does that mean that our doctors are sending in their bills more promptly or does it mean that we are actually rendering more services to our patrons? In the first six months of this year, we had an increase of 35 per cent in certificate holders, but we had an increase of 38.7 per cent in cases reported by the doctors. There are four categories of service which are way out of line: (1) In general surgery there was an increase of 63.7 per cent, (2) in x-ray, 58 per cent, (3) in thoracic surgery, 45.9 per cent, and (4) in otolaryngology, not including tonsillectomy, 44 per cent. But to be noted was that deliveries fell off relatively, showing an increase of only 12.6 per cent. Otology increased 17.7 per cent and herniotomies, 21.4 per cent. The other items were approximately the same as the increase in membership. Ideally, doctors should report all these cases within the month in which services are rendered, then the experience tables, the necessary reserves, and the doctor's income would be much easier to determine.

FROM THE PUBLIC RELATIONS MAILBAG

(Continued from Page 1441)

"At a Woman's Auxiliary luncheon today our State President showed us a copy of your very eye-catching booklet, 'It's No Bargain.' In my estimation it is, to date, the best booklet that has been printed to convey to the public the bare facts about socialized medicine and I am anxious to acquire a large number."

MRS. G. F. CLAPP,
Washington, Pennsylvania

* * *

"You have done it again—in the form of your recently published pamphlet, 'It's No Bargain.' Everybody who has seen this particular pamphlet makes the comment that there hasn't been so attractive a booklet with the readability demand this has."

LEO E. BROWN,
Medical Society of the State of Pa.

* * *

"The Michigan program of Co-operation with the American People (C.A.P.) is being emulated by many other groups and organizations in the land. Latest to approach the American people from the "grass roots" level using the same plan is the NAM (National Association of Manufacturers).

J. E. LIVESAY, M.D.
Vice-Speaker,
MSMS House of Delegates

Editorial Comment

THEY KNOW NOT WHAT THEY DO

Apparently most bureaucrats have immature minds and the world has learned that immature minds in grown up bodies are dangerous. They may not facilitate the work of the devil by design but they seem unaware of the fact that he often rides to the kill on the backs of misguided "do-gooders." Thus, any government may be dispoiled by the people who provide government by the vote and fail to let those elected to office know what they believe in and what they want.

But ambitious bureaucrats, even with the voters' consent, cannot practice medicine without doctors. Physicians in possession of the necessary knowledge and skills and a clear understanding of the disastrous implications of socialized medicine should withhold their services in behalf of the people and pray for the bureaucrats on the ground that "they know not what they do."

Occasionally drastic measures are necessary to dislodge the devils mounted on the backs of evil "do-gooders." With ultimate good in mind our profession must not yield to honeycoated bunk as did our British professional brothers who now grovel in the grime of failure. Even at the expense of seeming obstinancy we must employ our humane judgment in behalf of national weal. Were not the American soldiers in Brittany using the posts that supported the crossroads crucifixes to support their telephone wires though ladened with lethal messages really in the service of God?

Whether we go the way of Gibbon's Rome or whether we survive to vindicate conservative democracy we will be right. With Henry Clay we would rather be right than president, especially when the president is wrong.—Editorial, *Oklahoma State Medical Journal,* October, 1949.

EVALUATES THE PROMISES OF MEDICAL SOCIALIZATION

In this country, the intellectual kinsfolk of the OPA ideologists are currently attacking the consumer's methods of handling his hospital and doctor bills. . . . The lack of satisfaction secured from expenditures for medical and hospital services has undoubtedly led many people to look favorably upon, or at least be willing to countenance some system of socialized medicine by which they would be forced to make payments to a government medical insurance fund. The U. S. proponents of compulsory governmental medical care have skillfully disguised the compulsion aspects by referring to their program as "National Health Insurance," which puts their drive for control of the consumers health expenditures in the best possible, though a wholly deceiving light.

Following a critical analysis of prospective costs and values returned under the proposed plan the editor asks pertinently:

Do U. S. consumers want to give the Power to "Society" or the federal government . . . to decide just how much of their income MUST be sent to the U. S. Treasury for medical care? Can they judge from the sales claims whether the new product will be better than the one they are now using? The decision is now in their hands, but it will be in the hands of politicians if consumers do not seriously, and promptly concern themselves with the problem.—Editorial, *Consumers Research Bulletin,* September, 1949.

IT'S YOUR MOVE, DOCTOR

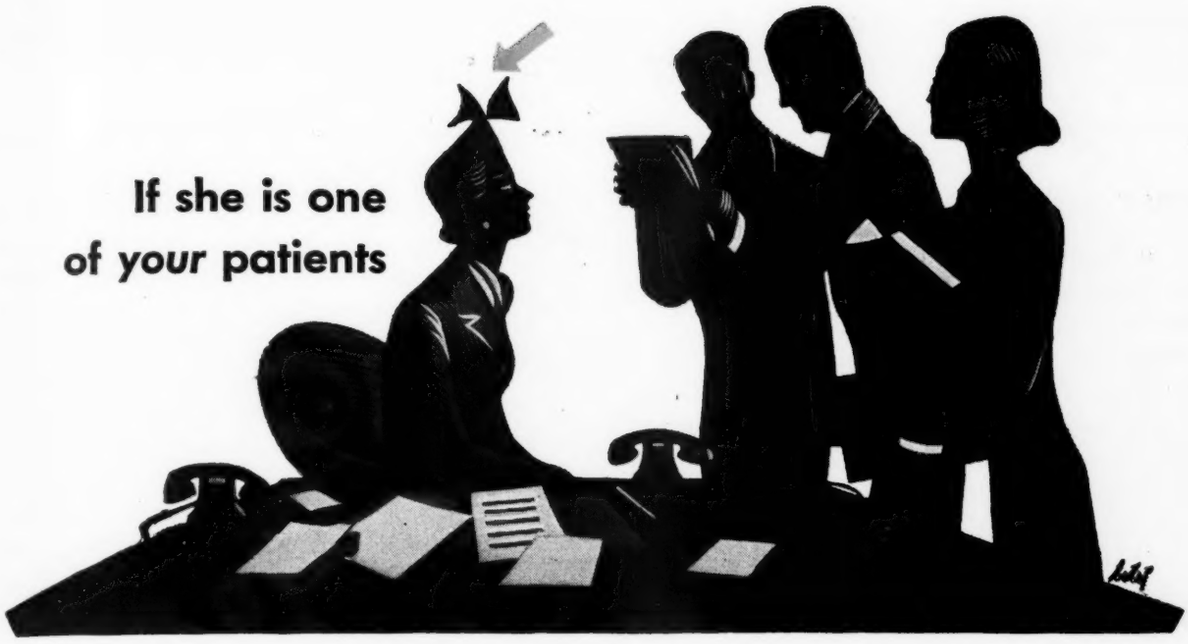
The English physicians lost their battle against Socialized Medicine because they were too polite to fight. This inertia proved a costly blunder, as most of the British physicians now admit. A stiffer fight may have prevented the chaotic condition now existing and lightened the taxes not only here but also in the British Isles.

State Medicine strictly is a political battle. Most physicians are against it but to date only a handful have done anything about it. A campaign of this nature requires more than all the Whitaker and Baxters in the country; it requires the combined co-operation of us all. The campaign requires the individual efforts of every American physician. The battle will not be won in Washington but by convincing patients and friends at home that State Medicine is bad medicine for the country. To do this every physician must know the facts, pro and con, as well as he knows the symptoms of appendicitis. It is the grass root strategy of campaigning in the local community that "brings home the bacon."

Many physicians think that they are too big to resort to grass root politics; others let it be known that they are so absorbed in the practice of good medicine that they cannot be bothered. We admire everyone who has the welfare of the public at heart but a new variable has been added to alter the picture. In our opinion, State Medicine lowers the standard of medical care and in this respect should stimulate the most conscientious physician to remove his gloves and get in and pitch. Nowadays a physician must be more than a good doctor if he wants to remain a free doctor.

We live in a free country but actually our fate rests in the hands of 435 congressmen and 96 senators. In other words, if we want the politicians to be interested in our cause, we must be interested

(Continued on Page 1450)



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Cancer Comment

FIRST MICHIGAN CANCER CONFERENCE

On October 11, 1949, the First Michigan Cancer Conference was held in Lansing. One hundred and twenty-five representatives of lay and professional organizations were in attendance. The purpose of the conference, which was sponsored by the Michigan State Medical Society, Michigan Department of Health and the two Michigan Divisions of the American Cancer Society, was to acquaint those in attendance with the nature and extent of the cancer problem in Michigan; and to invite the support of all organizations in a program of cancer control in their own communities.

A. E. Heustis, M.D., Commissioner of Health, in discussing the cancer problem in Michigan, emphasized its importance as the second cause of death and the part it plays in planning health programs in local health unit organizations. The widespread public interest in cancer control is stimulating national, state and local health agencies, both public and private, to give more consideration to the problem than ever before.

As cancer is now a reportable disease in Michigan, in time the development of a registry of known cancer cases may be expected. Such a registry will be of prime importance in furnishing information on the incidence and prevalence of cancer, information almost totally lacking at this time. The study of new and promising diagnostic tests gives promise of having available methods of examining large numbers of people in a minimum of time.

A. A. Humphrey, M.D., of Battle Creek, described cancer detection centers and their method of operation. For many practical reasons these centers have not fulfilled the hopes that attended their early development. Their limited capacity, their partial examination procedure requiring the one examined to consult some other physician whenever any suspicious lesion was discovered, and the high cost of each cancer found were among the reasons why detection centers as at present organized could not be expected to solve the problem of early diagnosis in the communities where located.

Dr. Humphrey emphasized that no matter where cancer detection examinations are made, in detection centers or physicians' offices, their value will not be determined by environment or available equipment but by the ability of the examining physician to understand and interpret his findings.

A. W. Strom, M.D., of Hillsdale, reported on the Hillsdale Plan for Tumor Detection that has been in operation in that county since January 1, 1948. Approximately 100 cancer detection examinations per month are made in physicians' offices during office hours. By appointment, anyone can secure this examination by his own physician for the regular fee for such service. Records of all examinations are filed confidentially with the county health department where they are available for statistical anaylsis.

The examination is confined primarily to the oral cavity, skin, breast, pelvis, rectum and prostate, although any suspicious findings elsewhere are followed to a definite conclusion. Cancer has been found in 3.5 per cent of those examined. Sixty per cent of the cancers found were in early and probably curable stages compared to practically no early cases found among those ill at home or hospital.

Dr. Strom stated that this program has stimulated participating physicians to a much keener interest in cancer diagnosis and treatment; and that by this Plan a more effective effort than ever before has been exerted in detecting and successfully treating cancer in that center.

Mr. Don E. Johnson, of Flint, discussed lay interest in cancer, and the part laymen must play in its control. Education remains the chief means of controlling cancer. Unless and until laymen are convinced that their only hope of escaping the serious consequences of their cancer is to seek periodic medical examination, little headway will be made in controlling the disease.

Mr. Johnson pointed out some of the responsibilities of the physician in the cancer control program. Among these responsibilities are those of educating the public, of being sympathetic to the interests and questions from the public, and to keep abreast of newer developments in diagnosis and treatment so as to offer their cancer patients the best service that science has provided.

(Continued on Page 1450)

FIRST MICHIGAN CANCER CONFERENCE

(Continued from Page 1448)

The formal program was concluded by Norman F. Miller, M.D., Ann Arbor, who offered a plan for the extension of the Hillsdale Plan to cover the entire state. He invited the co-operation of all health-minded individuals and groups to unite in making this program a reality in every county. He stressed the point that the proposed program need not interfere in any way with existing programs for cancer detection but could well serve those areas where no cancer detection programs had been set up.

It was recommended that each organization represented at the Conference appoint a representative to an advisory committee to the Cancer Control Committee which would explore the social, economic, educational, and other aspects of the cancer problem, and that reports on these studies be made to future similar conferences. Also that each one present urge the value of periodic medical examination on his friends and as a part of every pre-employment examination in industry. Such a program as outlined will place Michigan in the forefront of all cancer control programs in the United States and will, in time, give Michigan the lowest cancer mortality of any state.

Following luncheon, a question and answer period served to further explain the advantages of the Hillsdale Plan and to clear other points in the general cancer control program.

The periodic medical examination is the closest thing there is to cancer prevention.

* * *

The control of cancer is a co-operative undertaking between the public and the medical profession. All the scientific forces of the world are powerless in the control of cancer unless and until the public takes advantage of them.

* * *

Physicians cannot compel anyone to accept examination and treatment for cancer. Such services must be freely sought by the patient.

* * *

The physician's responsibility as a member of society is greater than that of any other group of citizens, because of the privilege of service in the field of physical and mental well-being that his medical training permits.

* * *

Mystery and fear are the ruling emotions in the savage or primitive mind. Civilization is achieved in large measure by the extent to which knowledge and hope replace mystery and fear. A long and important step will have been taken in cancer control when the greatest possible number of people have lost their fears and misconceptions of cancer through education and have become aware of the nature of the disease and the measures necessary for its control. Therefore, education remains—as it always has been—the most important element in the control of cancer.

* * *

More recent studies of surgically removed thyroid glands have demonstrated that cancerous tissue may be concealed in a symptomless goiter.

* * *

Nodular goiters in children are often malignant; the frequency of neoplastic change ranges from 19 to 40 per cent in different series of pre-adolescent children with this type goiter.

* * *

Radioiodine is being employed with varying degrees of success in the diagnosis and treatment of carcinoma of the thyroid gland. Several more years must elapse, however, and a great deal of work must be done before the clinical usefulness and the ultimate value of this substance can be properly evaluated.

* * *

The vast majority of tumors can be biopsied without harming the patient.

* * *

If physicians were to avoid incising suspicious lesions to obtain a biopsy then the early diagnosis of cancer would be impossible.

* * *

Clinical improvement has been noted in 80 to 90 per cent of Hodgkin's disease treated with nitrogen mustard. Remissions may last from two weeks to more than a year.

* * *

Cancer of the gingiva has one of the highest rates of metastases of all oral cancers.

* * *

Cancer confined to the stomach has a five-year survival rate of 50 per cent; if metatases to regional lymph nodes are present, the five-year survival rate drops to 5 per cent.

IT'S YOUR MOVE, DOCTOR

(Continued from Page 1446)

in theirs. It has been reported that in one city approximately one hundred physicians were not registered and could not vote if they wanted to. Inertia was also evident in the 1948 campaign. A plea for campaign money was sent by a republican organization to physicians in a certain county in Illinois. Not one of them responded even though it meant sending a loyal supporter to Congress. What would you think if you were a congressman and were asked to help a cause in which the constituents involved showed absolutely no interest? In the 1950 elections let us remember that it is easier to settle issues at the polls than in Congress at a later date.—Editorial, *The Illinois Medical Journal,* October, 1949.

Political Medicine

DON'T RUSH HEALTH PLAN, SPONSOR SAYS

Senator Humphrey (D., Minn.), a sponsor of President Truman's national health-insurance program, said that Congress must defer action on it pending further study and the enactment of related health measures.

The Minnesota lawmaker said he always has believed in the social-security principle of the proposed insurance program.

But he added that until the "practical difficulties" of administering the hotly disputed plan have been met, "legislative action might well be a disservice to the principle in which we believe."

Humphrey indicated he expects no final Congressional action on the bill next year. He thus lined up with two other sponsors of the measure who look for it to stay on the shelf through 1950.

They are Senators Thomas (D., Utah) and Murray (D., Mont.).

Humphrey set forth his views in a statement known to have been prompted by reports he was withdrawing his support from Mr. Truman's health-insurance program.

The program calls for bringing about 120,000,000 Americans under an insurance plan which the sponsors estimate would cost about $6,000,000,000 a year.

It would be financed by a three per cent payroll tax, split between employe and employer, on the worker's first $4,800 of annual income.

The American Medical Association and other foes of the program have contended it would lead to socialized medicine. Backers of the idea argue it is the best way to provide adequate medical care at a reasonable cost.

COSTS OF COMPULSORY HEALTH INSURANCE

Comdr. Paul R. Hawley in *Blue Print,* Blue Cross Commission, says the cost of compulsory health service is being kept secret by the Federal Security Agency. He writes:

"By two independent methods of approach to the problem, careful investigators have estimated the cost to be $100 per capita per annum when the program is in full operation. This is $15,000,000,000 a year. "The payroll deductions and employer contributions fixed by the Federal Security Administration will produce $6,-000,000,000 per year. Thus the contributions to the fund will pay no more than 40 per cent of the cost.

"Here I would point out that this huge cost is not for necessary medical care but largely to satisfy the capricious desire for medical attention for inconsequential ailments.

"In the present state of our national budget, can any intelligent citizen advocate adding $9,000,000,000 per year for the sole purpose of gratifying the demands of neurotics, malingerers, and chiselers?" *(The Christian Science Monitor,* Sept. 1, 1949)

SOCIALIZING INSURANCE

The United States is headed down the road to Socialism, and the insurance business will be the first to come under its rule. That bitterly unpalatable warning was made here by Senator Byrd at the annual meeting of the National Association of Insurance Agents. The Virginian's ominous words are the more credible because we've had a preview in this country during the past decade of socialized insurance.

For example, take social security. That New Deal device collects periodic payments from the individual and, if he lives long enough, restores this money and more in the form of old age insurance. Annuities do exactly the same thing. The difference is that social security is government-operated and imposes an equal contribution upon the employer; annuities are privately operated and each individual shoulders his own burden.

* * *

In the circumstances Senator Byrd's warning should provoke no skeptical retort. Not only is the insurance business headed down the road to Socialism, but its nose is already through the door.—*Chicago Journal of Commerce,* Oct. 3, 1949.

SENATOR HUBERT H. HUMPHREY AND VOLUNTARY PREPAYMENT PLANS

Senator Humphrey has changed his mind. He now says voluntary health plans should be aided and encouraged. Before this nation adopts compulsory health insurance, it should enact laws on Federal aid for medical education and local public health units; expansion of medical research, hospital construction, and the maternal and child health programs. He thinks the time is ripe for an extension of social security, but that the medical profession, the consumer, and the government should work together to bring voluntary prepayment plans to the peak of efficiency and economic soundness.

"Those of us who favor the principle of social security insurance recognize the practical difficulties of a nationwide program of health insurance that would directly affect the lives of every citizen in this nation. We understand that until these practical difficulties of administration are met, legislative action might well be a disservice to the principle in which we believe. . . . It is my considered judgment, therefore, that legislation for health insurance is not yet in the legislative action stage and will not be in that stage, regardless of its merits, until there have been further hearings, further research and until a primary basic administrative formula has been developed. . . . In view of the great need not now being met by existing voluntary plans, I urge upon the medical profession and the consumer the improvement of voluntary health plans and the extension of co-operative medicine, group health programs and the development of health services for industrial workers through the processes of collective bargaining."

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Subacute Bacterial Endocarditis

By George E. McKeever, M.D., and
Solomon G. Meyers, M.D.
Detroit, Michigan

WITH THE advent of penicillin therapy there has been made available an effective agent for the treatment of bacterial endocarditis. During the past five years penicillin therapy of this disease has been universally accepted as the treatment of choice. By the use of penicillin over 50 per cent of all cases may be cured![2] The rate of spontaneous recovery has been established at from 1 to 3 per cent.[7,11] It is generally agreed that best results will be obtained with early diagnosis followed with massive doses of penicillin over a long period of time.

Abstracts are presented of two cases treated successfully at Harper Hospital recently.

Case 1.—Mrs. A. K., a sixty-four-year-old white woman, entered Harper Hospital on June 25, 1948, because of sudden onset of substernal pain. There was no shortness of breath. Anorexia with a 15-pound weight loss had occurred during the last year. Physical examination revealed an elderly white female with slight pallor and in moderate distress. The temperature was 100.4° F. Lung fields were clear. The heart size was within normal limits with a rate of 92 and the rhythm regular. A loud systolic murmur was heard at the apex with transmission to the axilla and sternum; the pulmonary second sound was accentuated. Blood pressure was 160/90. The red blood count was 4,080,000 per cm. and the hemoglobin was 10.5 gm. or 68 per cent. Leukocytes numbered 9,600 per cm. with 86 per cent polymorphonuclear cells, 11 per cent lymphocytes, and 3 per cent monocytes. Hypochromasia and anisocytosis were noted. The sedimentation rate was 111 mm. per hour. A urine examination revealed a 3-plus albumin, 1 to 6 white blood cells per high power field, and 1 to 4 red blood cells per high power field. Electrocardiograms on June 26 and June 28 were normal. A chest x-ray showed slight cardiac enlargement in the ventricular area, and definite increase in the length and caliber of the aorta. X-rays of the gall bladder, gastrointestinal tract and lumbar spine were normal.

By the fifth hospital day, it became apparent that the outstanding feature of the patient's illness was fever, of which the patient was unaware. The temperature had averaged 102° F. for the first five hospital days. The fever, systolic murmur, weakness, weight loss, anemia, and the increased sedimentation rate suggested the diagnosis of subacute bacterial endocarditis. There were no petechiae or Osler's nodes, and the spleen was not palpable. By the twelfth hospital day, four blood cultures were found to be positive for streptococcus viridans, establishing the diagnosis of subacute bacterial endocarditis.

The patient was started on intramuscular aqueous penicillin, 100,000 units every two hours. The daily dosage and frequency of administration was changed a few times, but the dose ranged from 1.2 to 2.4 million units per day. The organism was found to be sensitive to 0.15 units of penicillin per c.c. *in vitro,* thus showing considerable penicillin sensitivity. The patient continued to have slight daily elevations of temperature to 99° F. despite penicillin therapy. On the thirty-sixth hospital day, the patient threatened to leave the hospital unless the frequency of injections was decreased, and the interval between injections was lengthened to three hours with no change in the total daily dose. At this point oral caronamide was begun in doses of 12 grams daily in divided doses. A marked increase in the penicillin blood levels was noted after the addition of caronamide. Before starting caronamide, penicillin blood levels ranged from .084 to .528 units per c.c. of serum. While on caronamide, the penicillin blood levels rose to from 5.215 to 7.936 units per c.c. of serum. The rest of the hospital stay was uneventful except for occasional low back pain and soreness of the buttocks from penicillin injections. By August 6, the patient was feeling well, having gained 4 pounds in weight. Seven consecutive blood cultures were negative. A total of 54.4 million units of penicillin had been administered during a thirty-two-day period.

From the Department of Medicine, Harper Hospital, Detroit.

At home the patient's course was completely uneventful. She continued to take oral caronamide in the same dosage. The family physician administered 600,000 units of procaine penicillin in oil (300,000 units in each buttock) daily for thirty-four days after discharge from the hospital. These injections were given at a daily visit which the patient made to the doctor's office. A blood count during the course of the home treatment was normal and a blood culture was negative. The patient was last examined on January 17, 1949, 130 days after discontinuance of treatment. She appeared and felt well. The temperature was normal and she had gained twelve pounds in weight since entrance to the hospital. Physical examination was normal except for the previously noted systolic murmur at the apex. Blood pressure was 180/100. The red blood cell count was normal with a hemoglobin of 83 per cent. The sedimentation rate was 47 mm. per hour. Urinalysis showed a trace of albumin. A blood culture 130 days after discontinuance of treatment was negative.

Comment.—The outstanding features of this case are:

1. Approximately one-half of the treatment was carried out in the home.

2. Penicillin levels of .528, .256, and .084 were elevated to 7.9 and 5.2 units per c.c. of serum by the addition of caronamide, using approximately the same dose of penicillin.

Case 2.—Mrs. S. K., a twenty-six-year-old white woman, entered Harper Hospital on July 23, 1948, because of weakness, malaise, ease of fatigue, and low grade fever. The patient had been well until six months prior to admission, when she first noted fatigue and headaches. About six weeks before admission the patient noted a furuncle on the surface of her nose. One month prior to admission she developed anorexia and nausea. One week before admission she developed a low grade fever of 100° F. There was a definite history of rheumatic fever at the age of six years, with no recurrences. A cardiac murmur was known to be present since adolescence.

Physical examination revealed a well-developed, well-nourished woman in no acute distress. The heart was slightly enlarged, the left border of cardiac dullness being just to the left of the midclavicular line in the fifth intercostal space. There was accentuation of the first heart sound at the apex. A systolic murmur was heard at the apex with radiation to the left axilla. The pulmonary second sound was accentuated. No diastolic murmurs were heard. Blood pressure was 88/50 and pulse was 80. The spleen was palpable on deep inspiration. No petechiae were noted. There was no tenderness of the fingertips. The patient ran a low grade fever, averaging 100° F. A diagnosis of rheumatic heart disease was made and studies were undertaken to determine if subacute bacterial endocarditis was present. A hemogram showed minimal degree of normochromic normocytic anemia and a leukocytosis of 12,000. The sedimentation rate was 40 mm. per hour. A urinalysis was normal. An electrocardiogram was suggestive of myocardial damage. Chest x-ray showed prominence of the left auricle and a short left cervical rib.

By July 31, the ninth hospital day, eight consecutive daily blood cultures had been found positive for staphylococcus albus. The organism was coagulase positive. A search was made for a septic focus. The urinary tract was studied by intravenous and retrograde pyelography and was normal. No staphylococci could be found in urine cultures. Clinical and radiologic examinations of the teeth were normal. Gall-bladder x-ray showed a radio-lucent shadow within the gall bladder which was thought to be due to a polyp of the gall bladder. X-rays of the upper gastrointestinal tract were normal. Ear, nose, and throat, gynecological, and proctological consultations were unfruitful in locating a focus of infection. A diagnosis of subacute bacterial endocarditis caused by staphylococcus albus was made.

The organism was found to be sensitive to 2.5 units of penicillin per c.c. *in vitro,* showing a high penicillin resistence. Treatment was begun on July 31 with 200,000 units of aqueous penicillin intramuscularly every two hours, a total daily dose of 2.4 million units. At the same time, 12 grams of caronamide was given daily in divided doses. On August 9, an urticarial rash appeared on the knees and elbows and a measles-like rash on the trunk. This was interpreted as a drug rash due to penicillin. The dosage of penicillin was cut down to 100,000 units every three hours and pyribenzamine (an antihistaminic) was administered. The rash progressed until August 12, and then subsided. On August 17, the daily penicillin dosage was boosted to 1.2 million units daily, on which she was maintained until procaine penicillin in oil was begun on August 31. Negative blood cultures were drawn on August 4, 7, and 10. During the eleventh day of treatment the patient refused the penicillin injections and there was a resultant ten-hour break in the treatment. Blood cultures taken on August 14, 17, and 18, were again positive for staphylococcus albus. The patient was started on streptomycin in addition to the penicillin on August 21, because of failure to sterilize the blood stream with large doses of penicillin. She received an average of 2.4 grams of streptomycin daily intramuscularly until September 10, at which time it was discontinued because of severe vertigo. Cultures were negative after August 18. As the patient's condition improved, her morale declined, so much so that the problem of persuading her to remain in the hospital to complete the course of treatment became a major one. It was, therefore, planned to start the patient on procaine penicillin, 2 c.c. twice daily, with the objective of carrying on this regime at home after discharge from the hospital. A decided increase in penicillin blood levels was realized after changing to procaine penicillin, even though the same daily dose was used. The blood levels rose from the levels of 2 to 4 units before procaine penicillin to 8 to 10 units per c.c. while on procaine penicillin. The remainder of the hospital stay was uneventful. She was discharged on September 10, to continue with the penicillin therapy at home as

planned. A total of 61,150,000 units of penicillin was given during forty-two hospital days.

The patient's course at home was uneventful. She was seen twice daily by the visiting nurse and given intramuscular procaine penicillin in doses of 1.2 million units daily for the first sixteen days (1 c.c. in each buttock twice daily), and 1.8 million units for the subsequent twenty-five days (1½ c.c. in each buttock twice daily). The vertigo, which began in the hospital, presumably from streptomycin, persisted for a few days and disappeared. She remained afebrile and symptom-free. Five blood cultures were obtained by having the patient visit the hospital laboratory approximately once weekly during the course of her home treatment. These were all negative. Serum penicillin levels were checked six times and ranged between 2 and 8 units per c.c. of serum. While on 1.8 million units of penicillin per day, they ranged from 3.9 to 8 units per c.c. of serum. The last day of treatment was October 21, 1948. The duration of home treatment was forty-one days which followed hospital treatment of forty-two days. The total dose of penicillin was 116.5 million units. The total dose of streptomycin was 47.6 grams, given over a twenty-day period. The patient was last examined on January 11, 1949, eighty-two days after the termination of treatment. Physical examination resulted in normal findings except for a slightly enlarged heart, with a systolic murmur at the apex. The tip of the spleen was still barely palpable and tender. Temperature was normal, blood pressure was 110/60, and the heart rate was 68. She had gained 10 pounds in weight, and looked well. The red and white blood counts were normal, with a hemoglobin of 86 per cent. The sedimentation rate was 25 mm. per hour. Urinalysis was normal. Blood culture was negative.

Comment.—

1. Although Staphylococcus albus is an unusual cause of subacute bacterial endocarditis, it has been thus described.[19] The locus of entrance was probably the furuncle on the nose, which had disappeared by the time of admission. Eight consecutive blood cultures were positive for the organism and its pathogenicity was demonstrated by the positive coagulase test.

2. Intermission in treatment, when the patient refused injections for a ten-hour period, caused the cultures to become positive after having been negative three consecutive times.

3. The development of penicillin sensitivity as manifested by extensive rash did not deter us from continuation of therapy because of the serious nature of the patient's illness. The dosage was decreased, pyribenzamine given, and it was found possible to continue treatment and later on even to increase the dose.

4. The co-operation of the patient was best secured by infrequent use of procaine penicillin in oil.

5. The treatment was prolonged by carrying out the last half of the treatment at home, the visiting nurse continuing daily penicillin injections.

6. Control was maintained by weekly visits to the hospital laboratory.

7. The levels obtained with procaine penicillin in oil and oral caronamide were as high as could be achieved with frequent intramuscular aqueous penicillin in the hospital.

Discussion

Subacute bacterial endocarditis is currently being diagnosed earlier in the course of the disease because of an alertness as to its possibility, early hospitalization, and repeated blood cultures. The classical clinical picture will be seen less frequently, as efficacious treatment is available early in the course of the disease, and the diagnosis will rest more on early clinical phenomena plus bacteriologic findings and less on the clinical phenomena associated with the advanced stages of the disease. Early diagnosis will pay substantial dividends in lower mortality and morbidity.

Many papers have advocated continuous intravenous drip as the route of choice for administration of penicillin. The objectionable features of that method are obvious. Jones and Tichy have pointed out that there has been no significant differences in results by the various modes of administration.[5] Rather, results are governed by the length and intensity of treatment. A definite advance in treatment, as far as patient comfort is concerned, was established by the use of penicillin in oil. Geiger and Goerner[3] reported cures in two patients using daily injections of penicillin in peanut oil and beeswax. A third patient who could not be cured on massive doses of penicillin was maintained asymptomatic and with a sterile blood stream by daily injections on an ambulatory basis. As a result of their success, they suggested that home care could be possible with adequate supervision.

The use of caronamide makes it possible to maintain high penicillin blood levels with relative ease. Caronamide by its action on the renal tubular epithelium inhibits the excretion of penicillin in the urine. The only toxic reactions noted have been those of nausea and vomiting in some patients. Caronamide is closely related to the sulfa drugs and may in the future prove to have more toxic potentialities.[8] It should be mentioned that the caronamide excreted in the

urine is precipitated by a low pH. Therefore, tests for albuminuria, using acid solutions, may give false positive test for albumin in the urine.

With the use of the longer acting penicillin preparations, supplemented by oral caronamide, a certain portion of a long course of treatment may be carried out in the home. The economic burden may be considerably lessened by this plan. An initial period of hospitalization for diagnosis and observation and a trial of treatment should be undertaken. The length of this period would have to be determined on an individual basis. Most patients could then be discharged for home care under supervision. The visiting nurse can be used to administer the medications or the patient can come to the physicians's office. Follow-up laboratory work may be carried out on an ambulatory basis. It is felt that a much shorter period of initial hospitalization than was used in the two cases reported may be quite satisfactory in certain selected cases.

It is necessary to establish the sensitivity of the organism to penicillin *in vitro* before treatment is begun. This is done to determine if the pathogen can be eradicated with penicillin and also is an index to the dosage needed. The sensitivity may be rechecked during the course of treatment. An increase in resistance of the infecting agent is rare, but may occur.

The only method available of deciding whether or not a cure has been accomplished is by a period of observation after a course of treatment.[5] The sedimentation rate, fever, and white blood count are not valuable as indications of a cure.[1,9] Negative blood cultures do not establish a cure. In a series of autopsies of fatal cases of subacute bacterial endocarditis, nine out of ten were thought to have had sterile blood streams. Of these ten, eight were found to have viable bacteria in the vegetations.[4] If, after a period of four to six weeks, the patient remains well and afebrile, a cure may be assumed. The longer the patient remains well, the more certain the cure.

The prognosis of subacute bacterial endocarditis depends on early diagnosis, vigorous treatment, the presence of a penicillin-sensitive organism, and mechanical factors in the heart. Embolic phenomena and cardiac failure may cause death after the heart valve has been sterilized. Relapses usually occur within thirty days and are rare after fifty days.[5,9] The chances of reinfection are probably no greater than the chance of the original infection.

Summary and Conclusions

1. Two cases of subacute bacterial endocarditis, one with streptococcus viridans, the other with staphylococcus albus, both treated successfully, are reported.

2. Early diagnosis, based on early clinical phenomena plus bacteriologic confirmation, rather than on late clinical phenomena, will decrease the mortality and morbidity due to this disease.

3. The trends in treatment are toward more massive doses of penicillin and longer duration of treatment.

4. Treatment at home, using procaine penicillin in oil and caronamide, was effected in the two cases after an initial period of treatment in the hospital. This is a very practical addition to the treatment for it allows prolongation of treatment, fewer injections, less expense, and more comfort to the patient.

ADDENDIUM: The patients described in Cases 1 and 2 were contacted just prior to publication of this article. They were found to be well fourteen and one-half and thirteen months, respectively, after cessation of treatment.

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The freshman class in the medical schools of the United States soon will exceed 7,000 students compared with an average of 6,016 in the ten years prior to the war.—*New York Times,* Sept. 5, 1949.

Bacterial Endocarditis Caused by a Hemolytic Staphylococcus Albus

Treated With Aureomycin

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THIS CASE of subacute bacterial endocarditis is one of unusual interest because of the presence of a relatively rare pathogen—hemolytic staphylococcus albus[8]—the type of aortic valve deformity, perforation of the intraventricular septum with resultant involvement of the tricuspid valve, and embolic showers in both the pulmonary and systemic circulations. At no time did the patient have splenomegaly or significant hematuria, and the usual secondary anemia did not appear until the terminal phase of the illness. No evidence was found of pre-existing congenital or rheumatic heart disease. The total illness lasted fourteen weeks, a duration most unusual for this organism before the advent of the more recent antibiotics.[7] Finally, this case study illustrates the necessity of determining the resistance or susceptibility of the recovered organism to the various antibiotics now available for successful treatment of this diesase.

Case Report

V. S., a forty-three-year-old white man, had a sudden onset of lumbar pain and pain in the toes and ankle of the right foot on August 1, 1948. There was no antecedent upper respiratory tract infection. Within five days he developed a fever of 103.6°. He was seen by a physician on August 6, for what seemed an intestinal infection, for which he was given sulfaguanadine. On August 9, he developed dyspnea and an apical systolic murmur thought not to have existed on physical examination one year previously. On August 11, following a course of sulfaguanadine totaling 30 grams, he returned to work, but on August 13, he again became febrile and was then given oral penicillin. Fever continued, and on August 17, he had a sudden onset of severe "jabbing" pain in the right upper quadrant and some pain in the right ankle.

On admission, August 18, he complained of dull aching right upper quadrant pain. The patient stated he had had exertional dyspnea for several years, but industrial health examinations and a life insurance examination within the last five years had not disqualified him for work. He had experienced no chest pain or sudden severe dyspnea unassociated with exertion at any time. He denied rheumatic fever as a child but admitted he was frail and that he had scarlet fever at the age of eleven with residual deafness in the left ear. *It should be noted that a daughter and nephew have rheumatic heart disease.*

Initial examination revealed a powerfully built, well-nourished male who appeared acutely but not seriously ill. He had no cyanosis, orthopnea or petechiae. His blood pressure was 125/70, and his temperature and pulse were 100.4° and 106, respectively. There was almost complete deafness in the left ear. He was edentulous, the throat was not remarkable, and no lymphadenopathy was noted. On having him sit up, a head nod was seen and an aortic thrill was palpable. There was a loud systolic murmur over the aortic area with transmission to the great vessels on the right. This murmur was heard also throughout the precordium. In addition, there was a blowing diastolic murmur in the second intercostal space on the right, an apical systolic murmur and a diastolic murmur in the mitral area, the former referred to the left axilla, in retrospect caused by dilatation of the left ventricle, and secondary to an aortic stenosing lesion.[5] The left border of cardiac dullness was beyond the midclavicular line. The rhythm was regular. Both lungs were clear to auscultation and percussion, but excursions of the right diaphragm were limited. The liver was felt 1 centimeter above the umbilicus in the right midclavicular line and was not tender.

Examination of the extremities showed definitely clubbed fingers and toes, which the patient and relatives stated to have been present all his life. No edema was noted. There was a small, tender and erythematous nodular lesion on the right instep.

The original urinalysis was not remarkable, the Kahn test was negative, the erythrocyte sedimentation rate was 25 mm. per hour, corrected, and the leukocyte count was 21,850, with severe toxic granulation of the 87 per cent polymorphonuclear leukocytes. Agglutination tests for typhoid fever and undulant fever were negative in all dilutions, and the heterophile antibody titer was 1:32.

A long-distance film of the heart showed an increase in density above the diaphragm on both sides but no definite fluid, a fairly prominent aortic arch, and a slightly enlarged cardiac shadow. A blood culture obtained the day after admission showed a few colonies of hemolytic staphylococcus albus, and penicillin therapy was begun, with the tentative diagnosis of acute bacterial endocarditis.

The liver was not palpable after the first day. Penicillin reduced the degree of fever but a fastigium of 99.4° prompted an increase of penicillin dosage to 2,200,000 units daily in addition to caronamide (Staticin—Sharp and Dohme).[2] On the eleventh hospital day the dosage was increased to 3,200,000 units each day, and on the seventeenth day to 6,400,000 units daily.

The Michigan State Laboratory had reported the organism to be hemolytic staphylococcus albus with a penicillin sensitivity of 12.5 units. Urticaria developed

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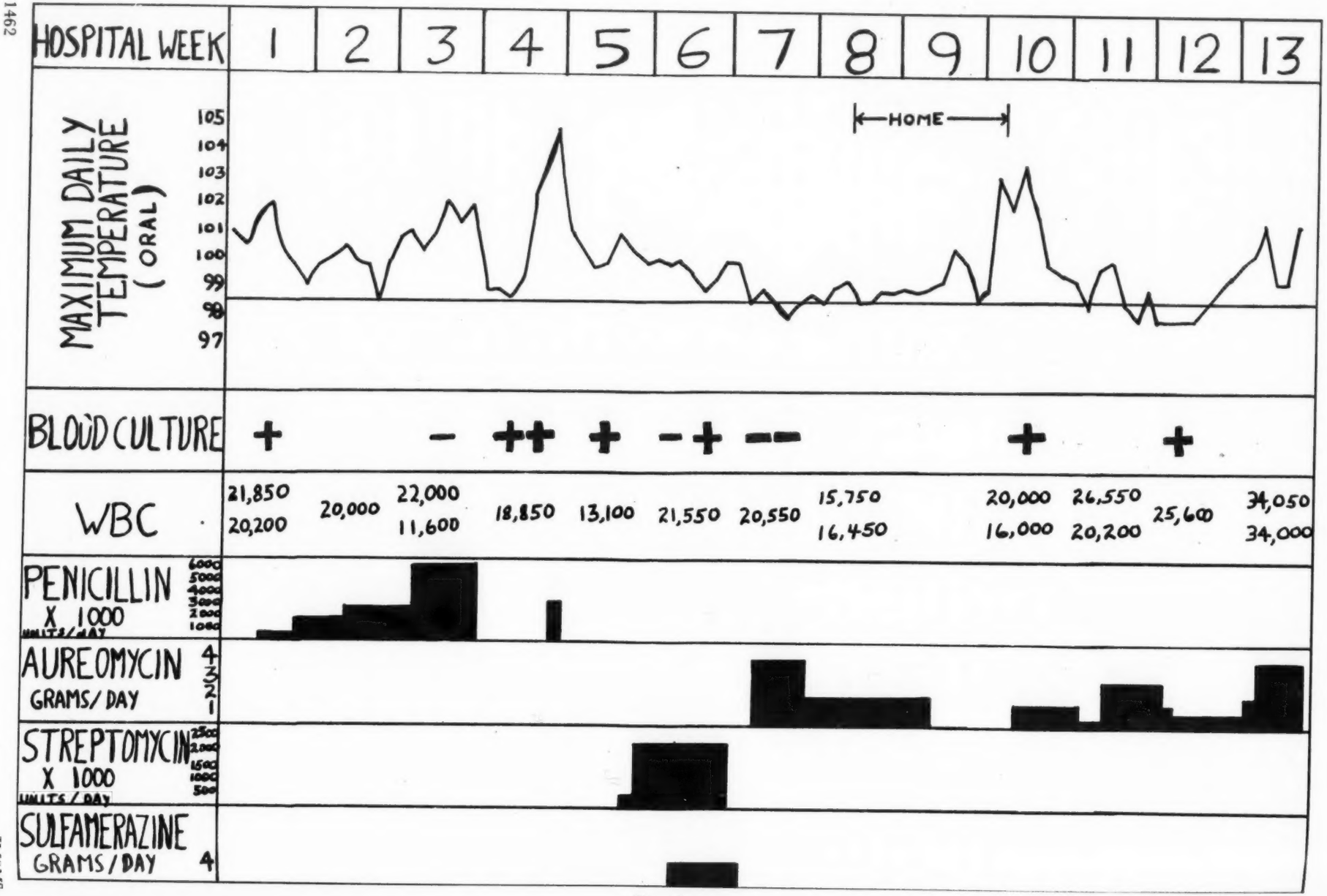
HOSPITAL WEEK
1
2
3
4
5
6
7
8
9
10
11
12
13
MAXIMUM DAILY TEMPERATURE (ORAL)
105
104
103
102
101
100
99
98
97
HOME
BLOOD CULTURE
+
−
++
+
−+
−−
+
+
WBC
21,850
20,200
20,000
22,000
11,600
18,850
13,100
21,550
20,550
15,750
16,450
20,000
16,000
26,550
20,200
25,600
34,050
34,000
PENICILLIN X 1000 UNITS/DAY
AUREOMYCIN GRAMS/DAY
STREPTOMYCIN X 1000 UNITS/DAY
SULFAMERAZINE GRAMS/DAY
4

Figure 1.

during this therapy and the temperature gradually rose despite a fall in the leukocyte count and a negative blood culture (Fig. 1). On September 6, a phenosulfonphthalein test showed only 25 per cent excretion in two hours, from which datum it was inferred that effective tubular blocking of penicillin by caronamide had been achieved, after the method of Boger,[2] renal disease having been excluded by previous normal urinalysis and a blood urea nitrogen of 15 mg. per 100 c.c.

The patient had reported on September 5 the onset of dull pain in the lower right anterior chest, with tenderness on percussion. A chest roentgenogram showed no change since that of admission.

When the fever reached 102°, penicillin and caronamide were discontinued, *with a prompt fall in temperature to normal and the reappearance of positive blood cultures, indicating both penicillin sensitivity of the host and penicillin resistance of the pathogen.* The urticaria, which had been controlled by antihistaminics, flared up again two days after these agents were discontinued, together with a rise in fever. The heart showed little change during the first week, with a rumbling diastolic and loud systolic murmur at the apex and a loud harsh systolic murmur over the aortic area.

On September 14, penicillin and caronamide were again given, and their use resulted in an immediate and alarming temperature rise to 104.8°. The prompt cessation of this therapy was again followed by normal temperatures for a day. There were noted some dullness, decreased breath sounds and decreased fremitus at the right base, and a survey film of the chest showed the persistent ill-defined pulmonary changes which still appeared most likely to be a pneumonitis, with some fluid at the right base. A small amount of fluid was aspirated, showing a predominance of polymorphonuclear leukocytes, but no organisms could be demonstrated nor a growth recovered on culture. On September 17 the temperature again began to rise, and on September 20 streptomycin[4] was begun as 300 mg. every three hours for a total daily dosage of 2.4 grams. The low-grade fever was not altered, and on September 24 sulfamerazine was begun in a total daily dosage of 4 grams. The combination proved equally ineffective. The use of aureomycin[3]* was suggested, and on October 1 it was begun as 4 grams daily for four days in four divided doses, and then as 2 grams daily as a maintenance dose. Blood cultures just prior to this therapy and again after five days showed no growth. The patient became afebrile and showed no evidence of toxicity. The chest findings cleared both clinically and roentgenologically.

He was allowed to go home on October 9, for financial reasons, after several days of instructing his wife in the use of the thermometer, and he continued taking aureomycin as an out-patient. On October 15 he noted redness of his fingers, hands and toes and some increase in dyspnea. Thinking these developments might be due to aureomycin, he stopped the drug on his own initiative, although practically afebrile up to that time. His temperature and pulse then gradually began to climb, with a sharp rise in fever to 103° on October 21. He was readmitted that day, showing the ravages of both toxicity and cardiac decompensation, necessitating oxygen therapy in addition to the usual supportive measures, including a diet containing 200 mg. of sodium, and digitalization. A blood culture obtained at this time was positive for hemolytic staphylococcus albus. Urinalysis showed only 1 erythrocyte per high-powered field and no albumin. The leukocyte count was 20,000 with 85 per cent polymorphonuclears. The hemoglobin was 75 per cent, and the erythrocyte count, 3.6 million.

Stab cultures of the organism were sent to the Lederle Laboratories for determination of sensitivity to aureomycin. The report from Dr. Hardy was interpreted as of high degree, but of course not directly comparable to a sensitivity test for penicillin.

Three sets of electrocardiograms, including all chest leads as well as unipolar leads, were obtained during the course of his illness. The second and third groups demonstrated a small infarction in the anterior wall of the left ventricle, as well as an increased P-R interval.

An x-ray of his chest on October 22 showed further progression in the amount of congestion in both lung fields, as well as fluid at the left base. On October 23, following a temperature elevation to 103.8°, aureomycin was begun in divided doses of 1.5 grams per day, and there again resulted a temperature fall, followed in two days by redness of his hands and itching of his finger tips, for which antihistaminics were given and the treatment continued. There were a few episodes of violent coughing accompanied by blood-flecked sputum, and a roentgenogram revealed a small pneumothorax involving mainly the left lower lobe. On October 26, he complained of nausea for an hour or more following each dose of aureomycin. Beginning October 28 was the first of several attacks of acute anoxia, characterized by inability to breathe, ashen color and excitement. The aureomycin was reduced to 1 gram daily in two divided doses. On October 30, the aureomycin dosage was increased to 3 grams daily, again followed by nausea. Once again, following adequate dosage, the patient became afebrile and remained so until November 6. After a rise to 100.4° on November 7, the temperature fell, until four days later it completely escaped and rose to 101°, which level was maintained with occasional spikes to 102° and 103° till his demise.

On November 9, a thoracentesis performed in the ninth right intercostal space yielded 1,000 c.c. of sterile straw-colored fluid. A pericardial tap on November 11, revealed no increased amount of pericardial fluid. The leukocytosis increased to 34,000 on November 12, with 89 per cent polymorphonuclear forms and 6 stab cells. On November 13 began episodes of mental aberration, characterized by memory lapses and confusion. Blood transfusions were given on November 12 and 14. The patient died November 15 in respiratory arrest.

On postmortem examination, one liter of straw-colored fluid was found in the right pleural cavity. Massive adhesions throughout the left thoracic space fused the parietal and visceral pleura. Both lungs were involved by multiple small pulmonary infarctions, atelectasis, focal areas of emphysema and very pronounced pulmonary edema and congestion. An old area of infarction measur-

*Supplied for experimental use by the Lederle Laboratories through the courtesy and interest of Dr. S. M. Hardy.

Figure 1.

ing 2 by 2 cm. was present on the anterior surface of the right lower lobe. There was a moderate degree of bronchitis and peribronchitis. The heart measured 12½ by 8½ by 13 cm. and weighed 625 grams. There was a very intense epicarditis with active pyogenic cellular infiltration. The mitral valve measured 115 mm., the tricuspid 120 mm., the pulmonic 90, and the aortic only 40 mm. There was myocardial hypertrophy, chiefly of the left ventricle, where the musculature measured 20 mm. in its thickest portion. At the apex of the left ventricle was found a fairly recent septic myocardial infarct, measuring 3 cm. in its greatest diameter, and several small septic infarcts were present elsewhere deeper in the myocardium. *On the surface of the aortic valve was a firm coalesced verrucous vegetation 4 cm. long, which completely fused two valve cusps and encroached upon the edge of the third. At one point in its attachment was a defect which represented an erosion through the cusp, that overlay the ostium of the right coronary artery. The vegetation extended through the intraventricular septum to involve the tricuspid valve, where it was quite friable and measured 1 cm. in its largest diameter.* Serial cross sections showed that the center of the vegetation which thus involved both sides of the heart was so necrotic as to resemble canalization. The endocardium of the mitral and pulmonic valves was smooth and the cusps showed no deformity. A previously suspected mitral stenosis, based on the peculiar change in the heart sounds as the case progressed, probably was due to perforation of the intraventricular septum. There was no definite evidence of rheumatic heart disease, and no Aschoff bodies could be found. The aorta in its ascending portion showed moderate to severe arteriosclerosis. The coronary arteries were sclerosed but not occluded. The spleen was not remarkable except for passive congestion.

The liver weighed 2,500 grams. Seen on microscopic examination it represented fatty degeneration of moderate degree together with marked cholangitis and pericholangitis. On the anterior surface of the right lobe of the liver was a completely fibrosed infarct measuring 3½ cm. in its greatest diameter. The gall bladder showed evidence of chronic cholecystitis. These findings explained the right upper quadrant pain about which the patient rather constantly complained. Only a few and very small septic infarcts were present in the kidneys. Examination of all other organs, including the brain, revealed only the changes of chronic passive congestion.

Discussion

In this case it is probable that the patient's illness began as either acute rheumatic pancarditis, or a congenital valvular defect followed by the implantation of one of the more unusual organisms on the aortic valve, causing rapid ulceration through the intraventricular septum with a very large coalescing valvular thrombus. The progress of this case is similar to that commonly seen in gonococcic endocarditis,[6] in contrast to the clinical progress of the usual nonhemolytic streptococcal subacute endocarditis. Although the organism, hemolytic staphylococcus albus, was highly sensitive to aureomycin, the intense ulcerating endocarditis, established before this antibiotic was administered, precluded recovery.

However, the case again illustrates the previously emphasized[1] importance of determining the relative value of an antibiotic to a pathogen at various times during treatment. In this case the high resistence of the organism to one and its extreme sensitivity to another illustrates this point.

This case history emphasizes the necessity for the development of a simple technique by which sensitivity may be determined between a given organism and all antibiotics now available in a given case.

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There is evidence all over Britain of the tremendous appeal of a plan that promises the public comprehensive medical care almost without limitation and at no direct cost. The Government has yet to deliver on this promise, but as long as there's any chance of it doing so, most of the people want to let things take their course.—RICHARDSON, *Medical Economics.*

Only one-seventh of the annual cost of the British Health Service is paid by contributions from workers and employers; the balance is paid out of taxes, which in income taxes alone now amount to 45 cents out of every dollar a poor man earns and 97.5 cents out of every dollar a rich man acquires. In addition, there are indirect taxes, sales taxes, profit taxes, inheritance taxes and so on and so forth that take from 24 to 100 per cent on the balance. Any Briton can avail himself of the Health Service as indeed can any American or Canadian, Turk or South Sea Islander who happens to be in Britain and feels himself in need of an appendectomy or a new set of dentures. British doctors may take any private patients they wish, provided any can be found who have anything left to pay medical fees after they have paid their taxes. British socialism leaves everyone perfectly free to get any private medical attention he wants, it simply does not leave him any money with which to buy any private medical attention or much of anything else.—*Richmond, Virginia, News Leader,* Sept. 20, 1949.

Common Sense and Heart Disease

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WITHIN THE last few years we have seen a great increase in interest and concern on the part of the public in regard to heart disease. The reasons for this are not hard to find. Chief among these are the appreciation that heart disease is the leading cause of death in this country, the realization that some types of cardiac difficulty, particularly coronary artery disease, may cause sudden death or long periods of disability, often at a relatively early age, and the large amount of publicity in newspapers, magazines and the radio concerning these and related matters. Much of this information has been on the sensational side or even been plainly misleading, but it cannot be denied that the American people have become heart conscious.

This situation is reflected in changes that have taken place in the American Heart Association and the rapid establishment of local branches of this parent organization in many states and smaller communities in recent years. Until recently the American Heart Association was a purely scientific organization made up solely of physicians, but this is no longer true, and lay members are also being included in many of the local societies recently formed. It is certainly true that the inclusion of prominent executives and business methods will bring in large sums of money, much of which should be spent to support research and teaching activities, particularly postgraduate instruction, in the field of heart disease.

If one looks realistically at the situation, it is clear that the incidence of heart disease can be cut down or the condition of the cardiac patient can be benefited in only two ways. Progress in the first direction must depend on successful completion of basic research work which will tell us, among other things, much more than we now know regarding the causes for hypertension and rheumatic fever. Research activities may also lead to improved methods of treatment for the patient with heart disease, but if we are to accomplish a great deal in looking after the individual who has (or who thinks he has) heart disease, we must have physicians with good common sense and adequate basic training in the diagnosis and management of cardiac patients. These immediately foregoing matters will be discussed in more detail presently, but a few more comments must be made concerning research.

Research of any kind, and medical research is no exception, costs money. The collection and allocation of funds for this purpose is, however, no guarantee that investigation of any value will be done. Ability to carry out really fundamental and important research work is, unfortunately, rare. Imagination, persistence and the spark of genius are some of the qualities that characterize the great investigator. It is to be hoped that a conscientious effort will be made to find individuals of this type and to give them the money and the opportunity they need to carry on. Whether these exceptional men or women are on the staff of a medical school or working elsewhere, they should be relieved as completely as possible of routine teaching, clinical or administrative duties. Otherwise, their efforts will be unnecessarily handicapped.

What can be done to help the average physician to do a better job in looking after patients with heart symptoms or disease? The answer to this question may be partly better undergraduate and more and better postgraduate training. The former is difficult to achieve because the undergraduate curriculum is already overcrowded, and it is doubtful whether even intensive teaching efforts at this time would help the individuals involved to do a much better job of caring for heart patients later on. Postgraduate medical education is a much more promising way to attack the problem, but unfortunately some physicians who need additional training and new ideas refuse to take advantage of such opportunities.

A great deal can be accomplished to improve the treatment of heart disease, real or fancied, in the immediate future, if the physician can develop a more optimistic attitude toward cardiac problems and if he can be made aware of some common mistakes in diagnosis and treatment. Doctors are more heart conscious today than ever before and are inclined to blame the heart for sudden death or other things when there is no clear evidence that this organ is abnormal. This is one reason why heart disease is, according to mortality statistics, the leading cause of death to-

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day. It is not implied that the above-mentioned factor is as important as other things, such as increase in average life span (due to improved treatment of other diseases, particularly pneumonia and tuberculosis) or improved methods of diagnosis, in causing heart disease to occupy the unenviable position it now holds. It is inevitable that many individuals in middle and old age will die of cardiac difficulties, since the heart is one of the vital organs necessarily affected by the aging process. Death in many patients, who we now know die of coronary occlusive disease, would have been ascribed to "acute indigestion," or something equally vague twenty and more years ago. Heart disease cannot be dismissed as a trivial matter, but if physicians keep the points enumerated above in mind, an attitude of optimism can be maintained.

A good history and a careful physical examination are and always will be the most important things needed to make an accurate cardiac diagnosis, and many more mistakes can be traced to neglect of these basic procedures than to failure to take an electrocardiogram. As a matter of fact, some of the most pathetic errors are made because the electrocardiogram is relied upon to the exclusion of the history and physical findings. Precordial pain is a very common complaint, and many individuals with discomfort in this region suspect heart trouble and consult a physician. The wise and well-informed doctor will, at this point, take the time required to obtain a detailed description of the character of the pain, its primary location and possible radiation, the duration of individual attacks, and factors that may bring it on or may relieve it. From an adequate description of the pain, it is usually possible to decide with a high degree of certainty whether the discomfort is angina pectoris or is not of cardiac origin. The history alone makes it possible to establish a diagnosis of angina (or to rule it out) in most instances, and it is particularly important in this condition, since physical examination and all laboratory procedures, including electrocardiograms, may be entirely normal.

The essential nature of the history in the circumstances mentioned above is obvious, but it is scarcely less important in the work-up of many other patients. Consider for a moment a young woman who comes to a physician complaining of shortness of breath. This patient has been worried about her heart because someone in her bridge club told her that this symptom indicates heart disease. The first job of the physician should be to find out just what the young woman means when she talks about shortness of breath. He often finds by careful questioning that she has no true dyspnea but "seems to have trouble getting air in and out and notices frequent sighing respirations." Further inquiry reveals that dizziness and numbness of the hands and feet are often associated with her breathing difficulties. These facts point clearly to a functional rather than a cardiac cause for the shortness of breath, and when the absence of heart disease is confirmed by physical examination, the physician is in a position to reassure the patient and point out to her the nature of the symptoms.

An adequate physical examination is no less important than the history. The examination of the patient suspected of heart disease should not be limited to the heart alone, since many other findings, such as orthopnea, engorgement of the neck veins, hepatomegaly, edema, petechiae, et cetera, may be important. If one is to examine the heart properly, a logical and systematic approach is important. If, when the physician has finished the examination of the heart he can answer the following questions, the examination has been a satifactory one.

1. *Is the heart enlarged or not?* This can usually be determined by careful percussion.

2. *Is there any abnormality of rate or rhythm?* This can also usually be decided by careful auscultation.

3. *Are the heart sounds unusual or abnormal in any respect?* Paying careful attention to the heart sounds and looking for deviations from the normal will pay dividends here.

4. *Are any extra sounds present, and, if so, are they in systole or in diastole?* Three sounds in each heart cycle instead of the usual two may produce a gallop rhythm, if the heart rate is rapid. A gallop rhythm is usually of no significance if the extra sound is in systole or is a physiological third heart sound.

5. *Are any significant murmurs present?* Diastolic murmurs almost always mean organic heart disease, while systolic murmurs may or may not have such significance. Many individuals with normal hearts have systolic murmurs either at the apex or base.

6. *Are there other less common auscultatory*

findings, such as pericardial friction rubs present? A pleuro-pericardial friction rub may be heard over the heart and must be differentiated from a true pericardial rub.

Examination of the heart, particularly auscultation, is not always a simple matter, and experience is necessary if the physician is to become skilled in this field. It should be added that one can find great satisfaction by becoming expert in the auscultation of the heart. Infinite variety exists here, and one never ceases to learn.

Many individuals with normal hearts have systolic murmurs, and the physician must be on guard not to suggest or directly state that this finding means heart disease. A great many patients have had their activities unnecessarily limited or have been started on the road to a serious cardiac fixation by over-enthusiasm in the interpretation of systolic murmurs. The physician can usually decide whether a systolic murmur is or is not of significance if he makes proper use of the history, the balance of the physical examination, and has some understanding of the factors leading to the production of murmurs of all kinds. Should the doctor be uncertain regarding the significance of a murmur, it is far wiser to ignore it for the moment and re-examine the patient again subsequently, or to refer the individual to a competent cardiologist, rather than to assume immediately that the murmur means heart disease.

The history and physical examination require no expensive equipment but only the willingness to take the time necessary to carry them out. Physicians assuming responsibility for the diagnosis and management of cardiac patients cannot overemphasize these basic disciplines.

Laboratory procedures of various kinds, including electrocardiograms, have a place in the examination of cardiac patients. These things, generally speaking, should be used to round out or confirm impressions gained from the physical examination and the history. Occasionally electrocardiograms make it possible to establish a diagnosis which might otherwise be difficult or impossible, but this is rarely true except in certain of the arrhythmias and when myocardial infarction is present. If these records are to be used to best advantage, they should be interpreted with full knowledge of the patient's history and physical findings. This is particularly true since many electrocardiographic abnormalities are nonspecific in character; that is, they point to no definite etiologic or pathologic condition. When considered in connection with the important clinical findings, they may be helpful, but if taken alone may lead to nothing but confusion. Many patients have been told they have heart disease and have even been put to bed for long periods of time purely on the basis of minor abnormalities in the electrocardiogram, when there is nothing in the history and there are no physical findings to justify such a course. One must remember that electrocardiograms are records of electrical events associated with the heart beat and may be modified by peculiarities in the position of the heart, alterations in conductivity in the tissues, and other things of this sort that may be quite independent of serious structural heart disease. The wise physician will understand the limitations of these records and will always evaluate their importance in the light of the information gleaned from the history and physical findings.

Treatment of patients with heart disease cannot be considered in any detail here. We must remember that many patients are being given digitalis or other drugs for no good reason and not infrequently for heart conditions that are nonexistent, except in the mind of the physician. A sane and common-sense view relative to the use of therapeutic meausures whether they be restriction of activity or drugs, is important. Generally speaking, it is unwise to limit the physical activities of any patient more than is absolutely necessary, and it is certainly foolish to give medicines unless there are good pharmacologic reasons to indicate their use.

Finally, there is reason for optimism relative to most cardiac problems, and physicians can do a great deal to decrease cardiac disability and improve the morale of their patients and the public at large.

MSMS

Kaposi's sarcoma is twenty times more common in males than females. Radiation is the treatment of choice.

* * *

Glandular therapy is indicated only when a cancer of the breast is classified as inoperable.

* * *

Whenever laparotomy is performed, the physician should take that opportunity to examine the patient's ovaries.

* * *

The most important sign of carcinoma of the colon is a filling defect which may vary in size and shape but is usually localized.

Employment Problems Faced by the Cardiac Patient

By John G. Bielawski, M.D.
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ONE OF the principal goals of the Michigan Heart Association is to increase employment opportunities for individuals with heart disease. The importance of heart disease in relation to employment cannot be over-emphasized. It has been established that at least 8,000,000 persons in the United States have some form of heart disease.[4] Due to the increasing average life span, this number is steadily rising with the addition of those in whom the aging process is affecting the cardiovascular system. It is a problem, therefore, which affects not only the individual cardiac patient in his attempt to be a useful, productive, and self-supporting member of the community, but also affects our entire economy and social structure, for if all these individuals were considered unemployable, the effects would be tremendous. For these reasons the Michigan Heart Association has instituted a state-wide community service in the form of a consultation service to business and industry in the many problems incident to the employment of cardiacs. This service is not concerned with the clinical examination and diagnosis of individual cases but with their employability and placement in suitable jobs.

The key to proper utilization of the cardiac patient, as with other handicapped persons, is proper job placement. Physical capacity of the patient must be correlated with the demands of the job. Although this formula sounds simple, it is often difficult of execution. Many factors serve to complicate the situation, and particularly in the mass production industry, so prevalent in Michigan, is this true. Understanding of some of the complicating factors will do much to aid the practicing physician in helping his patients solve these employment problems. This communication is presented not as a detailed guide to job placement of the cardiac patient but as a broad picture of the employment problems faced by him. It is based on the experiences of the Michigan Heart Association's Consultation Service to Business and Industry. This service is provided not only to the industrial physicians of firms large enough to maintain a medical service but also to smaller firms to whose problems, because of their lack of a medical department, special attention is directed.* The consultations are individualized, advice being based on a study of the problems as they exist in each particular situation. This is a practical, concrete service, by means of which it is hoped that employment opportunities may be increased for persons with a cardiac disorder to the mutual advantage of the disabled employe and his employer. The response and interest shown in this program, not only by industrial physicians but by executives concerned with personnel problems, has been gratifying. We have discovered that industry is aware of this problem and is eager for help in its solution.

Why should industry be interested in heart disease? Simply because the average age of its employes is rising, just as is that of the general population, and with it comes the rise in heart disease previously noted. Progressive management policy is to keep these older employes in spite of their defects. This is not only due to pressure from labor unions but also because industry recognizes its moral obligations to its older employes and because these older workers are the "spark plug" of the productive labor force due to their skill, knowledge, and loyalty. Industry, therefore, can and does employ cardiac patients even though there are certain risks entailed. The most important of these has been the compensation liability incurred. Naturally an employer does not look with favor upon any factor which may raise his costs. This has, however, been less of a problem than might be anticipated. Compensation litigation involving the cardiac person has been sparse in Michigan. Extension of the second injury clause of the compensation law to cardiac patients and other non-visible disabilities might also help in decreasing the reluctance of employers to accept persons with cardiac disease. Another risk frequently cited is the possible danger to other employes or to property in the event of a sudden heart attack. This danger is not present if the patient is properly placed in a suitable job. Absenteeism and labor turnover are among other objections cited by employers to the employment of the cardiac. The experience gained during the war has proved to industry that the handicapped, properly placed, have a good work record, show less absenteeism,

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*This service is now available to employers and industrial physicians. Address inquiries to: Michigan Heart Association, 4421 Woodward Avenue, Detroit 1, Michigan. Temple 1-6400.

less labor turnover and better production with less work spoilage than the unimpaired. The successfully placed, handicapped worker thus ceases to be handicapped in productivity and in earnings.

The practitioner may ask why, if industry is so interested in its employes, do some of his patients have difficulty in returning to work after a period of illness? Why do some of them tell their doctor that they are expected to go back to their previous job even if the doctor has advised it is too strenuous for them? To answer these questions, let us follow the patient back to the factory gate and see what influences are at work.

First of all, most industries have certain rules concerning time lost from work due to illness. Many request a note from the attending physician stating the patient is ready to return to his job. In plants having a doctor this note usually is meant for the industrial physician, in distinction from the insurance form the patient brings in for his doctor to fill out, which form in most places is kept in the insurance office and does not go to the industrial physician. The patient will usually be able to tell his doctor if there is a physician at the plant. In the note it might be wise to incorporate a statement of the specific limitations on work advisable and, with the consent of the patient, the diagnosis. After all, if the insurance office already has a diagnosis, why not give the industrial physician the diagnosis? In most instances this is treated as confidential medical data. Addressing this note to the medical director of the company rather than, as so often is the case, "to whom it may concern," will insure its arrival at the intended destination. Armed with this knowledge, the industrial physician can then proceed to arrange for suitable work for the patient. It is a pleasure for the plant doctor to co-operate in this way with the attending physician in arranging for proper job placement for the patient. On the other hand, it is an unsavory task to try to ferret out what might have been the illness when the note merely states, "John Jones has been under my professional care and is now ready to return to work." John Jones, furthermore, fearing loss of his job, a cut in pay, or due to misunderstanding, may lead the industrial physician astray, to his own detriment.

A case in point was recently seen in an industrial clinic; the patient came in with just such a letter. He had been on sick leave from work for three months, which he said was due to "bronchitis" and proposed to return to his previous work of heavy buffing, which is very strenuous. Referral to his record showed that three months before he had been brought into the plant hospital pale, sweating, and complaining of severe substernal pain. His private physician had been called and had arranged for hospitalization and care. A telephone call to the attending physician was made, disclosing the patient had suffered a severe myocardial infarction and now was ready for only the lightest kind of work and had been so advised. Further questioning of the patient disclosed that buffing was the only skill he possessed, and, in spite of his doctor's recommendations, he felt he had to go back to it or lose his job. Arrangements were made to translate the attending physician's recommendation of light work into a seated inspection operation involving handling of small parts, without any production level to maintain. True, it took an additional week before this new job was found, and it did not pay as well as the old one, so that the patient was still quite unhappy. Yet what would his feelings have been if he had lost a leg in an automobile accident? That, too, would have disabled him for the old job; but having a visible handicap, he would have welcomed the new one with its lower pay.

One thing the attending physician can do in this respect is to impress the patient with the nature of the limitations of his nonvisible cardiac disability and their economic implications. Another is to get in touch with the industrial physician in advance of the expected date of return to work so that preliminary steps in planning for proper job placement can be taken and suitable work is ready when the patient returns to his place of employment. This can most readily and efficiently be done by telephone. This type of program not only can be accomplished, but it is being accomplished at the Eastman Kodak Company in Rochester, New York, except that there the plant doctors have taken the initiative in the program. It is possible there because of a very close liaison between the company and the practicing physicians of the community developed by the company's part-time employment of many of these physicians early in their practice. Whether it is the industrial doctor who calls the attending physician or vice versa is immaterial as long as the contact is made for the benefit of the patient. It would seem feasible in most instances for the attending physician to make the initial call to notify

the industrial doctor of the problem and get the planning for suitable placement started. After all, it is the attending physician who knows just about when his patient will be ready to return to work and what his physical capacity will be.

Where the name of the industrial doctor is not known, inquiry for the medical director will usually enable the plant switchboard to place the call properly. Instances where this approach is not feasible will, of course, arise. It might then be a good plan for the attending physician to instruct his patient or indicate on his note to the industrial doctor that a telephone call relative to the status of the patient would be welcomed. Of course, not all plants have a full-time industrial physician. Many have an arrangement whereby a doctor visits the plant on only certain days and hours. In such instances telephone communication may be difficult due to the difference in the schedules of the attending physician and the industrial doctor, but a little extra effort will usually result in success and be repaid by the greater emphasis and fuller understanding achieved. Other plants may have only a nurse available, or there may be no provision for medical care within the plant. In such a case it would be wise to reach the general manager and explain to him not the diagnosis but the nature of the patient's restrictions and also capacity in order to obtain his understanding and co-operation in the proper placement of the patient. Naturally, it is wise to emphasize what the patient can do, rather than what he cannot do, in talking to employers. In these smaller plants which do not have any industrial physician, the telephone call of the attending physician may be the deciding factor not only in successful selective job placement but even in actual return to work of the patient, for the manager, like most lay people, may believe that the diagnosis of cardiac disease entails total permanent disability and precludes further employment. Changing these concepts is the job of the entire medical profession, and it is the practicing physician who is the key figure in the campaign. Attempts to enlarge employment possibilities for the cardiac patient by programs such as that of the Michigan Heart Association are only supplementary. It will take the continuous interest and support of all physicians in Michigan to make this program a success.

Of course, not every industrial establishment is co-operative, nor does every case receive ideal job placement. Fortunately these situations are not as common as in the past, for modern industrial management puts great emphasis on good labor relations, and the problem of the handicapped employe is an important part of this program. Even with a management sincerely interested in the return to work of the patient, proper placement in heavy industry may be a difficult problem. The individual with some special ability may be placed fairly easily, but all too often the cardiac patient is a person who up to his illness had performed only heavy unskilled labor and does not have the dexterity to perform a light task, for usually unskilled work is either slow and heavy or light but fast. Furthermore, the mental strain of meeting production standards may be as harmful as heavy physical labor, as for instance in the patient with angina pectoris. That these cardiac patients, however, can and do return to work has been amply demonstrated. Keresky and Goldwater[1] some years ago found that 65 per cent of the 2,081 patients attending various cardiac clinics in New York City were doing some type of work. Master and Dack[3] found that of 415 patients who survived the acute episode of coronary artery occlusion, 53 per cent returned to work. The literature is replete with instances of long survival after myocardial infarction. It is, therefore, definitely worth while to return most cardiac patients to work, providing proper job placement can be accomplished. When a suitable job is found, other factors may complicate the transfer. Labor's own hard-won and highly prized seniority system sometimes interferes. One plant was recently visited where transfer of a cardiac patient from heavy press work to a light job in another division was refused by the patient because by terms of the union contract he lost his job seniority by the transfer, and thus would be the first laid off when work was slack and the last to be recalled when it picked up. The reverse was true in the press room, but work suitable to his capacity just did not exist there. In some situations transfer is impossible. The railroad engineer who develops cardiovascular disease usually cannot be transferred to other work because of union rules. Some provision in union contracts should be made to render the transfer of the handicapped for the purpose of selective placement less difficult.

These are some of the factors that are encountered when a change in job placement is made necessary by heart disease. In some instances, however, the patient must seek a new field and a new employer. He now encounters new difficul-

ties. He no longer receives special consideration because of seniority of service with that employer but must compete with all others seeking a job. Unless he has some special skill or ability which is in demand and which entails a job within his physical capacities, the patient has a difficult time. The employer hiring unskilled labor usually wants men whom he can switch from one spot to another; therefore, he desires men who are physically qualified for heavy work. In most of the heavy industries of Michigan there are few unskilled light jobs, and these are filled by employes with long terms of seniority. Thus it is important for the patient who develops degenerative heart disease to try to return to work for the employer with whom he has established seniority. It is even more important, however, for children with rheumatic and congenital heart disease to acquire skills and knowledge which will pave their way to successful employment and consequent self-support and self-respect in adult life. This calls for insistence on at least grade school education and later realistic vocational guidance towards this goal. The importance of education to the youthful cardiac patient cannot be stressed too strongly. Responsibility for this is shared by the family of the patient, the attending physician and the school system. The State of Michigan, as part of the Department of Public Instruction, offers the services of its Office of Vocational Rehabilitation to assist in the program. These services are available not only to the young cardiac patients (to whom it is offered commencing at about age sixteen) but also to the adult individual with cardiac disease and to all who because of disability need this help. Service information, medical diagnosis, guidance (including testing, counseling and planning), cost of tuition for training, and placement services are provided without cost to disabled persons. Other services require an investigation of financial resources. A medical report form is sent to the family doctor. This is needed to determine eligibility and as a guide in providing vocational rehabilitation. Reimbursement for the necessary medical examination is made according to the Michigan State Medical Society Fee Schedule for Governmental Agencies. The Office of Vocational Rehabilitation may be contacted by the patient through one of its eight district offices, by writing to the central office in Lansing, or through the local office of the Michigan State Employment Service.

The Michigan Heart Association, in order to help meet some of these employment problems of the cardiac patient, has instituted a program designed to help develop techniques and experience in the placement of cardiac patients within industry. Further work planned within industry is to accomplish a survey of an industrial population in order to determine the incidence of cardiac disorders in such a group, and by follow-up of cases found, attempt to correlate the effects of various kinds of work upon the course of heart disease and thus assess the suitability of various occupations for cardiac patients. In time it may be possible to develop a service for the unemployed cardiac patient, a service similar to that of the Bellevue Work Classification Unit,[2] combining diagnosis and functional assessment by the physician with vocational guidance by a trained job analyst, designed to reveal the full employment possibilities of the patient and thus lead to satisfactory job placement. Other services under consideration include a vocational therapy program for the cardiac patient confined to his bed or home.

Summary

The importance of the productive employment of individuals with cardiac disease is discussed. The key to utilization of the cardiac patient is selective job placement based on a correlation of job demands with physical capacity. Ideal job placement requires close co-operation between the attending physician with his knowledge of the patient's capacity and the industrial physician with his knowledge of job demands. Methods of securing close liaison between them are outlined. The problems encountered in returning to the job after cardiac illness are contrasted with those of the cardiac patient seeking to work for a new employer. In order to help meet these problems, the Michigan Heart Association has instituted a consultation service to business and industry. This is a community-wide service in the many problems incident to the employment of cardiac patients and is part of a program being developed to increase employment opportunities for individuals with heart disease. The support and continuous interest of every physician in Michigan is necessary to attain this goal.

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Periarteritis Nodosa

A Review and Two Case Reports

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IN 1852 Rokitansky[21] presented his original treatise on a new disease of the blood vessels. In this article, three cases were reported and the necropsy findings were discussed. The pathologic process described is similar to that of periarteritis nodosa. Recognition of this vascular disease can therefore be dated back to 1852. In 1863 Virchow,[26] in his *Cellular Pathology,* reported a condition in which the pathologic findings were similar to those described by Rokitansky. He called the condition, "endoarteritis nodosa deformans."

In 1866 Kussmaul and Maier[15] gave a very thorough and classical description of this disease of the blood vessels, including histological studies. Since that time the condition has been called Kussmaul's disease, Kussmaul-Maier disease, endarteritis nodosa deformans, polyarteritis nodosa, and, more commonly, periarteritis nodosa. It has also been described as one of the diffuse collagenous diseases.

Throughout the years this syndrome has received the attention of clinicians and pathologists throughout the world, and to date more than 400 cases have been reported in the literature. Despite the advance in modern medicine and therapeutics, little can be added today to what Kussmaul and Maier described and reported in 1866. Numerous theories and ideas have been advanced as to etiology and treatment but as yet proof and results have not been established.

Definition.—Periarteritis nodosa is defined as a multiple macroscopic and microscropic nodular inflammatory disease, which occurs in single and multiple foci, in the outer and middle wall of the smaller arteries of the body. Because arteries are present in all organs and tissues, the disease may occur locally or generalized. By the same token the signs and symptoms will be directly related to the parts affected.

Incidence

Periarteritis nodosa is considered to be a rare disease. In recent years, however, the number of cases on record has increased considerably, probably because the condition is now being looked for and recognized by clinician and pathologist alike. It is the author's opinion that additional instances would be found if more autopsies were performed on cases of sudden death now ascribed to cerebral accidents, coronary heart disease and the like. The disease has been reported in the white, yellow and black races, as well as in mammals.[14] It occurs more frequently in the male than in the female. Approximately 40 per cent of the cases reported are between twenty and forty years of age, but it can occur at any stage of life from two and one-half months to seventy years or older. There is no geographic or seasonal variance in its distribution.

Etiology

The etiology of this condition is still unknown. Syphilis was first suggested as the causative agent,[5,11] but antiluetic treatment was of no value, nor were spirochetes ever found in any of the lesions. Since many cases have occurred in the absence of luetic infection, this idea has been abandoned. It is known to follow infectious processes, and for this reason some men think it is due to a bacterial hyperergy. Others have thought it due to virus infection, while some have tried to explain it as a sensitivity to the streptococcus. It is the author's opinion along with others[12] that allergy is a definite factor in the etiology. The association of allergic phenomena with cases of periarteritis nodosa is much too frequent to be passed off as mere coincidence. Asthma is often present and in some instances has existed for more than a year prior to the discovery of the lesions of periarteritis nodosa. It has been reported[13] that upwards of 15 per cent of all the tabulated cases have a past or family history of allergic phenomena.

In 1931 Metz[18] produced lesions in laboratory animals similar to periarteritis nodosa by sensitizing them to foreign serum and the streptococcus. Others have reproduced similar lesions in the laboratory by sensitizing animals to various bacterial strains and filtrates.[8,17]

In 1937 Clark and Kaplan[6] brought into the picture the anaphylactic nature of the disease, in their report of two cases proven at autopsy, following pneumococcus serum sickness.

In 1942 Rich[19] came out with his interesting observations on the role of serum sickness and

sulfonamide therapy as a causative agent. He came to the conclusion that periarteritis nodosa is a manifestation of anaphylactic hypersensitivity, and that widely different sensitizing antigens can be responsible for the development of the vascular lesions in different patients.

In 1943 Selye and Pentz[23] reported that an overdosage of desoxycorticosterone acetate in rats produced the lesions of periarteritis nodosa and suggested that the condition may be of adrenal origin due to an excessive adaptive response of the adrenal cortex.

Some interesting work has been recently published by Pearl M. Zeek and associates.[27] They were able to reproduce the lesions in rats by placing silk around both kidneys. If only one kidney was wrapped, the lesions did not develop unless the other kidney was removed. Likewise, silk wrapped around any other organ or tissue in the abdomen did not produce the characteristic pathologic lesions. They also made the observation that the lesions that occur as a result of hypersensitivity to various substances such as the sulfonamides or to serums, although strikingly similar to those of periarteritis nodosa, are really different both as to type and distribution.

In 1947 Sullivan[24] showed that by injecting foreign protein, arteritis can be produced in experimental animals. This foreign antigen becomes fixed in the arterial wall and surrounding tissues. There is an infiltration of lymphocytes and monocytes around the vessel. However, if sodium salicylate is given intravenously well in advance of initial contact of horse serum antigen, the development of the arterial lesion is prevented.

It is apparent that the question of etiology remains to be solved. Marked advance has been made in recent years but the causative agent of periarteritis nodosa has yet to be discovered.

Pathology

The pathology in this disease is important because of the symptomatology. If only one organ is involved, the symptoms will be relative to that organ alone. When many organs or systems are involved, the bizarre symptomatology is unique, and it is in the latter that the correct ante-mortem diagnosis is more apt to be made. Periarteritis nodosa is considered to be inflammatory in nature involving the medium sized and smaller arteries of the body. In different stages and degrees all the coats of the vessels are affected. There is swelling, necrosis and fibrillation of the media, destruction of the internal elastic membrane and infiltration of the adventitia with polymorphonuclear leukocytes which are often eosinophilic. The outstanding change is the localized necrosis of the media of the involved vessels. The infiltration of the vessel walls with polymorphonuclear neutrophiles, lymphocytes and eosinophiles is marked. Exudation followed by necrosis occurs, which results in thrombosis and the development of small aneurysms along the vessels involved. Occasionally these small bead-like aneurysms are palpable along the course of the affected vessel, hence the name periarteritis nodosa. Due to these pathologic changes small vessels become occluded when the intima is finally involved, with secondary changes occurring in the tissues whose blood supply has been cut off. This usually means necrosis, infarction or degeneration, the extent of the involvement determining the symptomatology referable to the organ or organs affected. Following the acute inflammatory stage, healing takes place by the formation of granulation tissue replacing the hyalinized necrotic areas. The endothelium may proliferate with partial or total closure of the lumen of the vessel. Scarred lesions may become calcified, the calcium being deposited haphazardly in the hyalinized tissue.

As noted previously, Zeek and associates[27] differentiate between the lesions of periarteritis nodosa and those produced by hypersensitivity reactions to such things as the sulfonamides and serum sickness. They maintain that a very important criterion in the differential diagnosis of these two types of vascular lesions concerns the structure of the pre-exudative lesions.

In patients dying of periarteritis nodosa there are usually lesions in all stages of development, while in six cases of hypersensitivity studied, all of the lesions appeared to be much more nearly of the same age, and it was difficult to find pre-exudative lesions in patients who died within a few days after the onset of hypersensitivity. They also point out that periarteritis nodosa rarely involves the splenic follicular arterioles or the arteries of the pulmonary circulation (not to be confused with the bronchial arteries) as does the angiitis of hypersensitivity. Also periarteritis characteristically involves the arteries of the muscular type near the bifurcation. This was not found to be true of the condition described as hypersensitivity angiitis. It is evident that even

the pathological picture of this disease is still open to argument.

Symptoms and Signs

The onset varies from mild to violent but is usually typical of an infectious process. There is initial languor, chills and fever, headaches and insomnia. There may be diffuse muscular and joint pains and even peripheral neuritis. Gastrointestinal symptoms with anorexia produce progressive weakness, emaciation and anemia. Despite periods of apyrexia the patient continues to get worse and worse. In some cases the course may vary from acute to subacute to chronic, and back and forth, and may last for days to years. The liver and spleen may become palpable and the muscles are usually atrophied and tender. The blood pressure is elevated in many cases. Severe internal hemorrhages may occur. Renal involvement is common, the urinary signs resembling those of acute glomerulonephritis. Depending on the distribution and the extent of involvement, the clinical picture may be that of gastrointestinal, hepatic, renal, cardiac, or organic nervous disease, or combinations thereof. Cutaneous hemorrhages, purpura, urticaria are seen, as well as tender, reddened, painful, subcutaneous nodules involving the extremities. Occasionally peripheral thromboses occlude small arteries and digital gangrene results. Partial blindness may occur due to changes in retinal vessels.[21]

It is evident that there is no definite pattern as to symptoms. Except for the onset which is usually typical of an infectious process, the following clinical course depends solely on the extent and distribution of the lesions.

Laboratory

The diagnosis may be established by biopsy. However, the specimen must be removed from a region in which there is some sign of the disease such as a cutaneous lesion, a painful muscle, et cetera. Thus, at times, because of the variable distribution of the lesions, a biopsy may give negative results even though the disease be present. When the condition is confined to the abdomen, a diagnosis of acute appendicitis, cholecystitis or pancreatitis may be made and operation performed. On such material the diagnosis is sometimes established. There may be a moderate to severe leukocytosis as well as secondary anemia. It is estimated that from 10 to 12 per cent of the cases show an eosinophilia. One case on record showed 86 per cent eosinophiles on the differential count.[7]

Albuminuria and hematuria are not uncommon and the sedimentation rate is usually elevated. Azotemia is seen, particularly in the later stages of the disease.

Diagnosis

Almost any symptom or set of symptoms may occur. The clinical findings may vary from time to time, and this variation is responsible for a very confusing picture. Given a condition which creates the impression of an infectious process that does not respond to therapy, progressive decline of the patient, and a bizarre clinical picture, one is justified in including periarteritis nodosa in the differential diagnosis. A past history of allergic phenomena under such conditions should make one all the more suspicious. Final verification of the diagnosis depends on positive histological proof.

Boyd[2] points out the different clinical diagnoses made on subsequently proven cases of periarteritis nodosa. Under general infection were listed sepsis, rheumatic fever, Malta fever, miliary tuberculosis and typhus fever. Under cutaneous diagnoses were scarlet fever, purpura haemorrhages, lupus erythematosus and syphilis. Under the gastrointestinal system were cholecystitis, acute appendicitis, dysentery, peritonitis, pancreatitis, gastric ulcer and abdominal hemorrhage. Cardiac diseases were congestive heart failure, hypertension, coronary sclerosis with angina pectoris. Listed under diseases of the muscles and nerves were trichinosis, polyneuritis, radiculitis, Von Recklinghausen's diseases, polymyositis and sciatica. Pertaining to the central nervous system were meningitis and Wilson's disease. Thus the differential diagnosis depends on the organs involved.

Prognosis

The prognosis in periarteritis nodosa is poor, and although remissions occur the ultimate outcome is usually fatal. Even though there are cases on record reported as recovered or with unusually long remissions,[3,4,9,10,16,22,25] the difference of opinion among pathologists as to what constitutes the lesion of periarteritis nodosa as contrasted to other types of angiitis may cast the shadow of doubt on some of the reported cures. This in turn raises the question brought out by Banks[1] as to whether or not there may be a common denominator in

scleroderma, dermatomyositis, disseminated lupus erythematosis, Libman-Sacks syndrome, pariarteritis nodosa and hypersensitivity angiitis as described by Zeek. Further work and study are needed before these questions can be answered.

Treatment

As yet there is no specific treatment for periarteritis nodosa. The report of a cure by sulfapyridine[9] has not been substantiated in other cases. Strong supportive therapy is in order. It is important to build up the patient's resistance with a high caloric diet, vitamins and an adequate fluid intake. Small repeated blood transfusions may be helpful. Plasma and serum albumin may be used to maintain the serum proteins. Auto-inoculation of the patient's own blood may be tried. Because thrombi formation in the vessels is so common, the anticoagulants may be tried. The antihistamines because of their proven value in allergy should be used empirically. A case in point has been arrested two years, and the only therapy used was benedryl. Such substances have not been available long enough to say whether or not they may be of definite value in the treatment of this condition.

Case Reports

Case 1.—Mrs. G. N., a twenty-two-year-old white woman, was well until March, 1946, when she developed an upper respiratory infection. A chronic cough persisted, and a diagnosis of bronchial asthma was finally made. Treatment consisted of benedryl, sulfonamides and finally tonsillectomy in July, 1946. No improvement was noted as a result of any of this therapy. Benedryl was continued, and in September the asthmatic condition subsided.

The patient became pregnant in October, and one month later the asthmatic episodes recurred. Treatment with penicillin, ephedrine, and theophylline afforded no relief. She was skin tested and subsequently started on desensitization shots plus a diet excluding the foods to which she had shown a sensitivity. The chronic cough persisted. In June, 1947, an eight-month premature child was born. Shortly after the delivery the asthmatic attacks ceased. In July the patient noted weakness and pain of the lower extremities. One month later she was hospitalized for a period of twelve days for a thorough study. A white blood count of 49,000 with 86 per cent eosinophilic leukemia.

She continued as an out-patient following her discharge and received physiotherapy to the lower extremities and vitamins by injection. No improvement was noted. Weakness and numbness of the hands accompanied by pains in the shoulders and arms gradually developed. There was also frequent gastrointestinal distress, and it was questioned as to whether this was related to the over-all condition or the medication. By October, 1947, a temporary improvement was evidenced and the appetite returned. There was a weight gain to 85 pounds, and an increase in strength and much less pain. During this interval however, recurrent episodes of hives occurred. In mid-February, 1948, coincident with the institution of liver therapy, anorexia again recurred along with frequent attacks of gastrointestinal upset. On March 30, 1948, the patient was first seen by the author. At this time she complained of weakness of the extremities, periodic rashes on the body, anorexia and nausea. Hospitalization was advised.

Past History.—During childhood the patient had chronic sore throats. There were the usual childhood diseases, none serious. Tonsillectomy was performed in 1946. There was no family history of allergic diseases.

Physical Examination.—The patient was very emaciated and appeared chronically ill. Weight was 83 pounds. Blood pressure was 110/76. The spleen was palpable 1 cm. below the left costal margin. The tendon reflexes were absent in both upper and lower extremities. There was a bilateral foot and hand drop. The extremities showed an ecchymotic rash which in places was slightly raised as if there were small aneurysms of the terminal blood vessels. This rash in other places appeared like an urticaria and was present on the hands, feet, legs, groin, axilla and abdomen. Over the eyebrow and forehead in the area of the large supraorbital arteries there were two small nodules in the blood vessels. There was a generalized shoddy lymphadenopathy.

Laboratory Studies.—X-ray of the chest was normal. Skeletal survey showed a moderate degree of demineralization of the bones of the arms and legs, characteristic of disuse atrophy. Blood studies revealed a moderate normocytic, normochromic anemia. The white blood cells were increased to 14,000-15,000 and the differential count showed a marked eosinophilia, averaging 40 per cent and consisting of segmented and non-segmented nuclei but none younger than this. There was a moderate hypoprothrombinemia. Examination of the bone marrow revealed a marked eosinophilic reaction with a shift to the left in those cells, to a degree seen in many eosinophilic states. There was no evidence of leukemia in the bone marrow smear. A biopsy of a lymph node from the posterior cervical chain showed extreme eosinophilia. Biopsy of the skin showed perivascular eosinophilia suggestive of periarteritis nodosa. Urinalyses, Kahn test and blood chemistry studies were within normal limits.

Subsequent Courses.—During the hospitalization period from April 4, 1948, to April 17, 1948, it was felt that sufficient evidence was obtained to make the diagnosis of periarteritis nodosa. The patient complained frequently of pain involving the extremities and also of abdominal cramps. It was necessary to use demerol to afford relief. Blood transfusions and general supportive therapy were administered. Following discharge from the hospital the overall course was downhill. Some

days she would be relatively free of pain and would eat well, while at other times opiates were necessary for relief. On May 20, 1948, she developed right lower quadrant abdominal pain, and a diagnosis of acute appendicitis was made and the appendix removed. On June 21, 1948, the patient developed nodules along the course of the radial and ulnar arteries in both arms. On June 29, 1948, the patient developed severe generalized pains and she was again hospitalized. She lapsed into a coma and expired the following day. No postmortem examination was performed.

Case 2.—Mrs. R. L., a twenty-nine-year-old white woman, was well until March 11, 1948, when she developed pain in the right side, followed by generalized pain in the abdomen, accompanied by severe diarrhea. A gastrointestinal x-ray series, four days after the onset, was negative. On the morning of March 22, the abdominal pain became more severe but was relieved by an enema. However, it recurred again at noon and was localized in the right side. There had been no nausea or vomiting.

Past History.—For one year the patient had asthma. Skin sensitivity tests were negative. Over this period there had been a 35-pound weight loss.

Physical Examination.—The patient was markedly emaciated and appeared both acutely and chronically ill. Blood pressure was 120/70. Abdominal examination revealed generalized tenderness, most marked at McBurney's point. There was spasm of the right rectus muscle. The remainder of the physical examination was negative.

Laboratory Studies.—The red blood cell count was 4,980,000 with 80 per cent hemoglobin. The white cell count was 25,000 with 76 per cent neutrophiles, 11 per cent lymphocytes, 9 per cent eosinophiles and 4 per cent monocytes. Blood chemistry studies were normal.

Subsequent Course.—The white blood cell count increased and an exploratory laparotomy was done on March 23. The intestines were studded with small nodules resembling miliary tuberculosis. Pathological specimen showed periarteritis nodosa. The appendix was normal.

The patient died at home shortly after discharge.

Conclusions

1. A brief review of the disease periarteritis nodosa, with both past and present day opinions on its various aspects, has been presented.

2. Two cases have been reported in detail, each of which was proven by pathological study. Both patients had an asthmatic history.

3. It is the author's opinion that the disease is much more common than has been reported, and that more autopsies in cases of sudden death would bear this out.

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(Continued on Page 1483)

Peripheral Arterial Disease

Recent Advances in Surgical Treatment

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THE REMARKABLE extension in life expectancy in the last 100 years, from forty-two to sixty-seven years, can be attributed directly to medical and surgical control of infectious, degenerative and malignant diseases. Were this rate of longevity to be continued for the next century, our grandchildren could expect to live to be ninety-two years old, and this is not without the realm of possibility. In one field, however, our attack on the problems affecting life has not kept pace. I refer, of course, to the diseases of degeneration and particularly to those affecting the cardiovascular system. Very little study or research has been expended so far in efforts to control this group, and in this respect we have been negligent. A budget for research of $16,000,000 for poliomyelitis with a death rate of 1,112, or $13,500 per death, compared to the return of $39,000 following the campaign of the American Heart Association for cardiovascular research with a death rate of 557,143, or 7 cents per death, is an example of this disproportion. Approximately 60 per cent of all those over fifty will die of some cardiovascular lesion, and when this is contrasted with the 9 per cent that will die of malignancy, and when funds and research work to control the two types of lesions are compared, the necessity of more work and research in the cardiovascular field is at once apparent. Our own recent report,[3] showing that in people who are working at forty years of age, arteriosclerosis is discernible in the peripheral vessels by x-ray in 40 per cent of all the men and 20 per cent of the women, is illuminating. This shows that these degenerating diseases begin much earlier than we thought—ten to fifteen years before the symptoms develop which bring the condition to the patient's attention.

In the patient with diabetes mellitus, the development of arteriosclerotic changes in the peripheral vessels is much more rapid than in the non-diabetic. All diabetic patients over forty will show these sclerotic changes, and the great majority of them will have changes discernible within the period of three years after the diagnosis of diabetes mellitus. It is not entirely clear why diabetics develop these arteriosclerotic changes so early. It makes one believe that possibly the faulty metabolism of fat products, which occurs so early in the diabetic and is dependent upon improper sugar metabolism, leads to the sclerotic changes rapidly. One may hypothesize that arteriosclerosis is a disease due to the faulty metabolism of lipids due to the failure of proper sugar metabolism, and in the pure arteriosclerotic person this inadequate sugar metabolism is subclinical. The possibilities of prophylactic treatment by the use of high carbohydrate diets and insulin have not yet been exhausted. While we know little of the etiology or the pathogenesis of these degenerating lesions, we are making strides in the management of the complications of these diseases. If we are able to manage their complications, these patients may continue a useful and provident life as long or perhaps longer than the ones without the degenerating diseases, because with their knowledge of their underlying pathologic condition, they take better general care of themselves.

It is my purpose in this paper to discuss the occlusive arterial diseases and the management of the complications at the various stages in which they are seen. The underlying pathologic condition is a medical and not a surgical one, and the surgeon enters the picture usually at the complication stage. Earlier surgical co-operation can forestall some of the complications. I wish to point out particularly the management of these lesions by some of the newer methods which are at hand. That such medical attention will be successful is attested by our reduction in the amputation rate in thromboangiitis obliterans from 55 per cent to 3.8 per cent in ten years.[7]

These occlusive arterial lesions are progressive, and in the light of our present knowledge it is to be expected that the occlusion eventually will become complete. It is our problem, therefore, to protect the vessels still functioning, prevent the complications which follow trauma or infection, and stimulate, if possible, the formation of other vessels. The problem is twofold. We have the occlusion problem as the major vessels close down with the symptoms of peripheral ischemia as shown by claudication, color, trophic and temperature changes, and the secondary problem that

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with this ischemia the part's defense against infection or trauma decreases. As these sclerotic and atheromatus changes occur in the major vessels, the arterial lumen decreases in size. Contiguous with this decrease is an effort to develop collateral circulation around such blocks, and this is most effective when the obliteration is slow. If successful, the circulation continues even after closure of the major vessels. Where the deposits are plaque-like, the vessel may continue to function normally until such a plaque is loosened by undermining and suddenly swings closed, not unlike a trap door, or produces an embolus. In such instances, the closing off of the circulation is sudden, embolic-like and shocking, and in a high percentage of these patients gangrene soon follows. In such instances, the occlusive process is an acute one and calls for emergency care. The patient is put to bed at once, and the part kept at or slightly below heart level. Measures to stimulate collateral circulation are then undertaken as will be discussed.

Prophylactic Therapy

There are certain fundamental or prophylactic medical measures without attention to which other therapy will fail. These are:

The Avoidance of all Vasoconstriction.—These patients should avoid exposure to cold or heat, and all physical constrictions such as garters, tight casts, et cetera, should be eliminated. When the major vessels become occluded, the part becomes more subject to spasm. This is probably on a reflex sympathetic basis. The plaque, thrombus, or calcium deposit in the vessel sends afferent stimuli to the ganglia; second order neurons stimulate the sympathetic cells, and these reflexly activate efferent stimuli which cause a vasoconstriction in the affected and collateral vessels. In the absence of disease in the vessel this reflex when it follows injury, is a defensive measure to reduce hemorrhage and squeeze out blood which might clot and prevent circulatory re-establishment after the insult is over. In occlusive disease, however, the insult continues and a vicious cycle is established.

In such a situation the introduction of a spastic drug such as adrenalin, ergot and especially nicotine is contraindicated. The use of *nicotine* which has become the common denominator of American social life, can swing the balance as to whether such a patient with an arterial lesion keeps his limb or not. The great importance of discontinuing smoking is not understood sufficiently. That all arterial occlusive diseases and not just thromboangiitis obliterans patients are effected by nicotine must be recognized. We have seen patients refuse to give up smoking despite the fact that they have been told they will lose their limb if they continue. We have seen patients, after the loss of one limb, continue smoking and despite all other types of therapy lose the other limb. Our reported basket case was an unforgettable instance.[7]

In many patients, an acute antipathy or allergy to nicotine is developed. In the patient who has diabetes mellitus, there is a further problem because the smoking of only two cigarettes can raise the blood sugar as much as 25 to 50 per cent, probably on an adrenalin-stimulating basis. One dislikes to become vehement on any subject, but after observing the impossibility of controlling the smoking habit in patients of this type, we wonder whether making nicotine addicts of all of our best stock at a very early age is not a national problem. This must be considered since over half of these patients, if they live to be fifty, will have some disease with which tobacco smoking is incompatible. Such well-meaning organizations as the Red Cross, the YMCA, the Knights of Columbus and others, by their smokers and donation of cigarettes, help in the creation of this tobacco problem. During the recent war those of us on duty near the fronts were surprised and shocked to see patients brought in an extremely poor condition, many times needing plasma or blood, but rarely without a cigarette hanging from their lips.[5] From my experience with a large vascular clinic I cannot overemphasize the importance of this smoking point.

Skin Breaks and Infections.—The second point is the avoidance of skin breaks by trauma or infection. In this respect, *hygiene* is important. We tell our patients to take better hygienic care of their feet than they would of their faces. We have them wash their feet two and three times a day with a change to clean stockings. The care of the nails is especially important. Some member of the family is detailed to do this important task, cutting the nails, after a thorough washing, in a good light with a sterile scissors. All pressure points which might start a focus of infection, such as an ingrown toe nail, corns or callouses, are avoided. In this respect, we must become podiatrists, and the prescribing of adequate sized shoes and stockings is

important. The attention to *fungus infection* which is probably common to us all is necessary because, by the skin breaks caused by this fungus infection, a portal of entry for secondary infection may develop. The evidence that the fungus alone causes the arterial occlusion is incomplete. The use of some mild fungicide, such as potassium permangenate in 1:10,000 strength, as a routine soak once or twice a week will control this problem. Any small collection of pus should be evacuated early. If any *local infection* does develop, it is treated energetically with chemotherapy, the right type of drug being selected for the organism if it is cultured. This chemotherapy is given both locally and generally, and in the case of penicillin massive doses may be used. In this respect, the saphrophytic organisms may be a factor, and their eradication by some of the higher galac acid preparations now becoming available, when used in combination with the other chemotherapeutic measures, may be a factor in the saving of a limb. *Focal infections* seem to play a part, if not in the actual onset of the condition, at least in continuing the process once it has been initiated. Such focal infections are usually found in the mouth, throat or sinus site. The dental caries is the most frequent offender. The patient with roentgen evidence of defective teeth usually will continue to have severe symptoms of arterial failure until these foci of infection are removed.

Stimulation of Collateral Circulation.—The efforts to stimulate collateral circulation should be unceasing. In the acute stage, bed rest definitely is indicated because the use of the legs creates a demand for blood which the part cannot supply. Sympathetic nerve blocks are employed repeatedly. Once the acute stage of arterial failure has passed, walking, always short of fatigue, will help to stimulate collateral circulation. Simple medical measures such as the use of a warm sitz bath or reflex warmth may be of help. Later, swimming, especially in a warm pool, will be of value, as the buoyancy of the water reduces the muscular activity necessary to keep up; we have our patients paddle their legs while resting the body on an inflated mat or raft. In this effort to stimulate collateral circulation, we have abandoned all mechanical measures and gadgets such as the suction pressure boot or the venous occlusion apparatus as being of questionable value and at times traumatizing. In a few instances in such acute closures where it is apparent that the circulation to the part is irreparably lost, the extremity may be refrigerated to reduce the oxygen demand of the part. This method of treatment is used in our clinic only when it is apparent that further efforts to stimulate or develop circulation to the part will fail. In a few instances such therapy has been effective, and in some in which the limb was thought to be lost, restoration of circulation has been achieved. This is effective in some uncontrolled infected diabetics where the ice and a tourniquet perform a bloodless amputation and permit time for preparation for actual amputation. The use of the pancreatic tissue extracts in certain individuals appear to reduce the claudication time. This is not a constant finding.

The *anticoagulant drugs, heparin and dicoumarol,* have a definite place in the therapy of these conditions. For example, it requires a much lower temperature to develop gangrene in a limb in which anticoagulant therapy is used, and in similar experiments animals can stand more trauma to their limbs in the presence of cold, with recovery in 50 per cent more of the cases when the anticoagulant drugs are used than without them (Blalock).[1] Experimentally, it has been found that the gangrene rate was zero in a group of sixteen rabbits subjected to refrigeration and treated with heparin, while gangrene developed in every control rabbit which was similarly refrigerated but not given anticoagulant therapy. In a similar fashion, in the patient who has ischemia, more occlusion and spasm are necessary to develop gangrene when the blood is supplied with anticoagulant properties. These drugs are being employed prophylactically at the present time and the results are extremely gratifying. The difficult laboratory tests necessary to insure safety when using the drugs and the technicians' long weekends have delayed their wider application. We have hope that either a simpler test for the prothrombin time will be evolved or it may be possible to slow the action of dicoumarol.

In the acute stage of occlusion we give heparin, 50 mg. intravenously and the same amount intramuscularly. The drug is continued in doses of 30 to 70 mg. every three hours thereafter to keep the coagulation time over fifteen minutes until there is dicoumarol effect. Dicoumarol is started with a 300 mg. dose and the daily dose based on

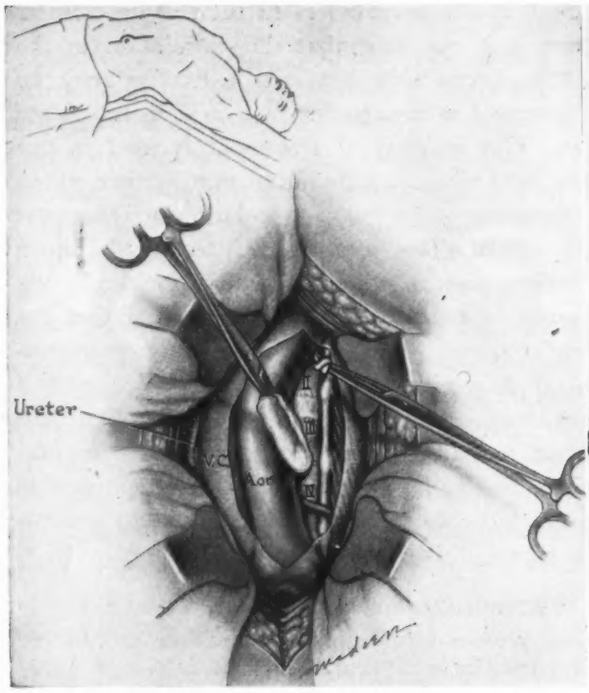

Fig. 1. Transperitoneal Lumbar Sympathectomy. Used where both lower extremities must be denervated. Abdominal contents packed in upper abdomen and retroperitoneum opened in mid-line. Aorta and vena cava displaced medially and chain removed.

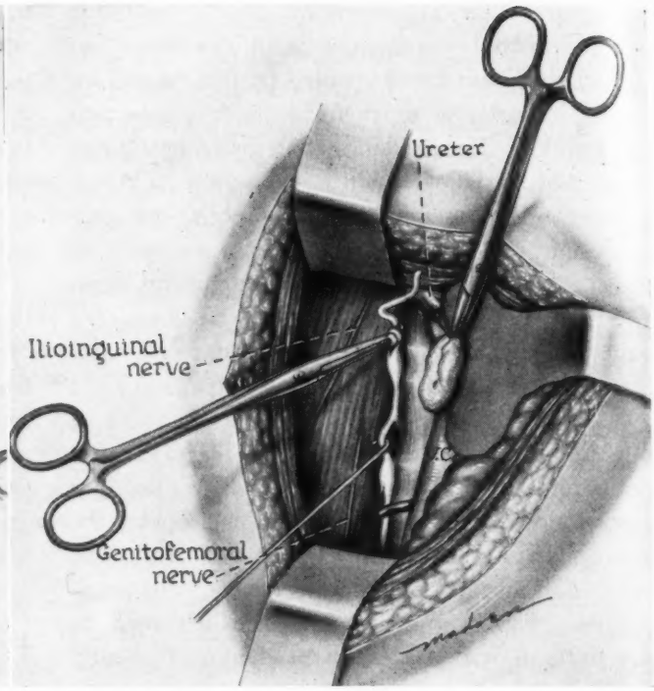

Fig. 2. Retroperitoneal Sympathectomy. Muscle-splitting lateral abdominal incision at level of *L 2*. Peritoneum pushed to mid-line and ganglia and chain removed by exeresis.

the prothrombin test, at present, as determined by the Link-Shapiro modification of the Quick test.

These drugs should be used in all acute episodes.

Interruption of the Sympathetic System

This therapy has had a rebirth and has a valuable place in the treatment of these occlusive lesions. We believe the calcium or thrombus deposit on the wall of the vessel sets up and continues the sympathetic synapse with reflex vasoconstriction of that vessel and other collateral vessels. In order for the interruption of the sympathetics to be of value, the operation must be timed properly and the patient selected carefully. Sympathectomy cannot be expected to bring dead tissue back to life, and if it is used at a time when gangrene is already present, the necrosis will continue. (Sympathectomy must be used prior to the onset of necrosis.) The result will be better in the patient who responds both clinically and with skin temperature increases to sympathetic nerve blocks. In others, where there is a poor or no response to the block, sympathectomy will still be effective probably, because the sympathetic block is technically not complete. Sympathectomy must be complete to be effective. The sympathetic system tends to reactivate itself more than any other part of the body, and it is our policy not only to divide the sympathetics but to excise the chain and ganglion. The good results depend directly on the thoroughness of the procedure.

There have been some recent reports that sympathectomy has precipitated gangrene. We do not believe this statement, and our experiences controvert them. We feel that if gangrene follows sympathectomy, it does so for one of two reasons: either the necrotic process was already irreversible before the sympathectomy was performed, or else the operation of sympathectomy itself traumatically caused an arterial thrombosis or embolism. In performing a sympathectomy, one is operating near the aorta and its major branches, and rought handling or retracting of these large vessels may loosen a plaque of calcium deposit with thrombosis at that site or a distal embolis. We have performed lumbar sympathectomy for the arterial occlusive diseases in over 112 patients, with amputation thereafter necessary only four times. In two of these four we were operating too late, as we now realize. In the other two, we operated to try to have a successful below-knee amputation, and in both of these the calf amputation healed well. Chemical interruption of the sympathetic system in the acute stage is of value,

but thereafter has not been satisfactory in this type of lesion in our hands, despite the good results reported by Coller and his associates. We have tried tetraethylamonium chloride and priscol but have not used dibenamine. The intravenous ether and intravenous novocaine have a transitory sympathectomy effect. The borrowing-lending effect of sympathetic interruption cannot be as effective when the system is interrupted generally as when it is blocked locally.

The Complication Stage

As long as these degenerating diseases are present, infections will make amputation in some a problem. We believe in ultraconservatism in the treatment of these occlusive lesions as long as this infection is minimal or controlled. It is our policy when a patient is first seen to give large doses of chemotherapy, use the anticoagulant drugs and perform sympathetic nerve blocks for forty-eight hours. To this we add warm soaks and the local drainage of any fluctuating areas. Each day after the soak loose slough is removed, avoiding pain or bleeding, as these latter symptoms indicate viable and not dead tissue is being removed. If the infection is then reduced or controlled, these procedures are continued.

Local (Digit) Amputations

Where possible, the part is allowed to self-demarcate and self-amputate, the tendons being left long as drains. Undermining is prevented and the ulcer kept saucerized. Sometimes a dead bone is rongeured away. Many of these lesions then will heal, and we have in our clinic innumerable patients who have been walking on a foot with parts of toes or parts of the foot gone for many years.[7] The x-ray appearance of these extremities is misleading, as areas of dead bone sometimes may be visualized. Secondary infections may develop which require drainage, and in some we give small courses of chemotherapy from time to time for years. These patients can be kept walking, however, and on their own limbs for many years if they are kept under observation in the clinic.

In this respect these patients should be considered like the tubercular or mental patients. They need protracted or continued care with repeated treatments for any complication. Cardiovascular sanitaria may be the ultimate answer, but until these are provided the attention of someone interested in their problem is necessary if success is to be expected. If this attention is given, these patients can be kept going on their own limbs for an indefinite time.

Through Foot Amputation

At the McKettrick Clinic, amputation through the foot is advocated when the blood vessel to one digit has become thrombosed.[4] This operation is based on the theory that with one digit affected, other digital vessels will thrombose, and further necrosis of this foot can be prevented by this amputation. For the healing of such a foot amputation to take place, the operation must be done early, and for this reason we rarely perform this amputation. We believe that many of our patients are walking on parts of their foot for longer periods of time than would be so if we amputated as early as it is necessary to operate for healing to occur when one amputates through the foot.

Below Knee Amputation

We perform relatively few amputations below the knee in the patient with advanced occlusive disease for the same reason. In order for amputations at this site to heal properly, the operation again must be done very early, and we feel that many of our patients who have their own legs today would have had an amputation had we elected to amputate below the knee. In other words, the questionable cases must have early amputations if amputation below the knee is to be done, instead of having a chance to possibly heal. To repeat, many of these patients do not require amputation at all. In the younger patient or one who has had a sympathectomy, these calf amputations are satisfactory.

Amputation Through the Thigh

Conservatism is continued until infection is uncontrolled or necrosis advances despite all measures. If the infection is spreading in the face of local and general therapy, and especially when it reaches the ankle, we believe an amputation should be performed, and procrastination thereafter will be reflected in an increased mortality. The defenses against infection are poor once the process passes the ankle. Because of the susceptibility to infection most of the diabetics require amputation through the thigh. The possibility of amputation should be anticipated, and permission and preparation for it started early to avoid delay when the time for action arrives.

Technique of Amputation

After considerable experience we have adopted a very simplified amputation technique.

Preoperative Preparation.—Chemotherapy, especially penicillin, is used in large doses before the operation. In elderly individuals the clostridium welchii and the bacillus prefrigens inhabit the colons, and since many of these patients are bedridden and partially incontinent, these organisms have been ground into the skin, during this bed stay. The skin of the thigh is prepared with soap and water three times, the last time being in the operating room. This skin preparation causes sebaceous glands in the extremity to secrete to exude these organisms which are then scrubbed away.

Anesthesia.—Refrigeration anesthesia has replaced all others as the one of choice. It is entirely effective and is applied as follows:

After premedication, the limb is elevated and placed in ice for a period of three hours prior to the amputation. The ice must completely cover the limb and must be continuously reapplied. Amputation can be done then painlessly except that the sciatic nerve must be injected proximally with novocaine, several minutes before its division. The amputation should be carried out by teamwork without noise or delay. To many patients an amputation is shocking and is like an execution, and the least bunglesome work is the kindest. The incision is made for the thigh amputation at the mid-patella area. The muscles and tendons are divided two inches proximal to the skin incision where they are mostly tendinous and the femur one inch proximal to this point of division. The vessels are opened, any clots in the vein withdrawn or aspirated until a free flow is obtained, and ligated with a transfixion suture. Embolism can be prevented by this measure. No periosteal or tendon flaps are made.

Care of the Nerve.—The nerve is divided last. It is tied on tension with a steel wire suture distal to the novocaine area and divided with a sharp knife. It is then permitted to retract. This method has been followed by fewer neuromata and phantom pains than when the nerve was injected with alcohol or plactically treated. Phantom limb is a normal condition. Phantom pain is abnormal. In some it is of psychic origin or it may follow neuromata. At times it is causalgic in origin. We have had no persistent phantom pain with this technique.

The wound is closed with interrupted steel wire sutures placed through the skin and superficial fascia only. The "dog ears" at either end of the incision are left open as drains. The simple closure is the important part of the operation. If flaps are made, pockets for pus are developed. This simple closure creates no dead space and permits drainage. Stockinette extension with approximately 3-pound weights is applied at once and continued for two to three weeks. The extension prevents retraction, and closes tissue spaces. Since the muscles are not raised from the bone above its division point there is adequate covering for the bone. The dressing is not disturbed for two weeks unless there is a general reaction.[7]

Rehabilitation

One of the real advances during the recent war was the program of rehabilitation for amputees. We have carried this over into the vascular field, and it is surprising to see elderly patients, whom one would expect to be utterly helpless, walking on their crutches within two days after a major amputation. The removal of these patients from the self-pity and helpless state to a position where they are able to take care of their own toilet and bath requirements is revolutionary in its effect. Where time permits, we begin the rehabilitation program before the amputation by discussing it with the patient, showing motion pictures of other amputees who have walked, preparing the patient's family and friends for the program and likening it to the replacement of lost teeth with an artificial plate. We find it is a fear of being helpless that has caused the mental change in amputees, and where this can be removed by making them self-reliant at once, a great part in the rehabilitation program has been accomplished. We try to have these patients do some type of work. Exercising in groups despite their economic level is of interest and stimulating to them, as they learn by the mistakes and troubles of others. I saw this evidence in one group of twelve amputees in young Marines from Saipan. These men were psychically shocked after their major amputations, but by keeping them in a group, exercising them and getting them joking about their own progress, it was possible in two weeks' time to change their entire outlook on life. When this

group was photographed just before being evacuated to the United States, they insisted that their stumps be shown in the picture. Many already had constructed makeshift limbs.

In this atomic age, with the development of chemotherapy and anticoagulant drugs rapidly removing syphilis, malaria and pneumonia from the unconquered field, I am sorry I cannot offer a specific therapy to cure all arterial occlusive diseases. From my study of them, I think those physicians who are waiting for some miracle drug for these lesions are going to be disappointed, at least for a long time. I do believe a clear understanding of the process as it develops, and the use of all therapeutic measures when applicable, will reduce certainly the incidence of gangrene and mortality in these patients. It is hard to picture one drug which could handle the process of degenerating cells with peripheral ischemia and at the same time control infection and develop new vessels. Until such a miracle develops, a stable understanding of the principles involved in these degenerating processes and their complications will save lives and limbs.

Summary

1. Arterial occlusive diseases present one of the great problems of today, and while we know little of the pathogenesis, we can do a great deal to help these patients therapeutically.

2. Certain fundamental measures are necessary in this therapy. These are the removal of all vasoconstriction, the avoidance of skin breaks and infections, and the stimulation of collateral circulation. The use of the anticoagulant drugs and sympathetic interruption will decrease the number of these patients who will develop gangrene.

3. While infection is kept minimal, ultraconservativism is continued. When infection enters the picture, it is treated by early drainage, adequate chemotherapy, stimulation of the collateral vessels, and conservatism as far as amputation is concerned while the infection can be controlled. When infection can no longer be controlled, amputation is necessary. When amputation is performed, a simplified technique stressing adequate general and local preparation, refrigeration anesthesia, simple closure, extension and rehabilitation will be successful in a high percentage of patients. Rehabilitation is a real part of the patient's care and should be the responsibility of the operating surgeon.

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PERIARTERITIS NODOSA

(Continued from Page 1476)

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Sickle-cell Anemia Complicated by Pregnancy

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THAT IT IS difficult for women with sickle-cell anemia to carry a pregnancy through to full term is borne out by the fact that to date only twenty-four cases have been reported. The case reported herein will be the twenty-fifth case to be published. It becomes of particular interest when it is noted that about 8 per cent of Negroes in the United States have the sickle-cell trait; that is, they have erythrocytes which are capable of becoming sickle-shaped in the proper media or under the proper conditions. About 0.2 per cent of Negroes are afflicted with the entity called sickle-cell anemia. Sickle-cell anemia is manifested by episodes of pain in various parts of the body, by attacks of jaundice, febrile episodes, liver enlargement, chronic ulcerations of the lower extremities and a very persistent and severe anemia with sickle-cells and nucleated erythrocytes in the peripheral blood as well as leukocytes, proliferation of reticulocytes, and a hypoplastic bone marrow. The case now reported is not only of interest because it is one of a Negro woman who became pregnant and who was delivered of a normal living child, but because this patient had no complications in labor. Most patients who become pregnant and who have sickle-cell anemia suffer from one of the complications of pregnancy, such as convulsions, severe and frequent headaches, hypertension and generalized edema along with other manifestations of the eclamptic syndrome. It is felt that these symptoms in the sickle-cell anemia patient are due to small thrombi in the cerebral vessels and in the vessels of other vital organs such as the pelvic viscera, the liver, spleen and kidneys.

Report of Case

History.—The patient, M. C., a twenty-one-year-old Negro woman, was first seen by the author on April 24, 1948. She complained at that time of amenorrhea and progressive enlargement of the abdomen. She stated that her skin had been itching, that the sclerae had been yellow for the past four months and that she had had trouble with her blood ever since she could remember. Several times during her life she had ulcerations of the lower portions of both legs. History further revealed that the patient's appetite had been good but she had been unable to gain weight. The bowels were regular but she was unable to eat fat foods or such foods as cabbage, beans or onions because of the resulting flatulence. Her urine had become very dark in color in the last two months. At the time of the examination at North End Clinic the patient had been married for two years. She became pregnant in 1947 but had a miscarriage after four months. The first menstrual period was at the age of twelve. She flowed for two or three days every twenty-eight days. The last menstrual period was April 1, 1948. The remainder of the systemic review was essentially negative.

Further investigation into the case revealed that on September 12, 1936, when the patient was eight years of age, the diagnosis of sickle-cell anemia was made a the Children's Hospital of Michigan and a splenectomy was done during that admission. She required a number of blood transfusions from time to time and her best hemoglobin level during that period was around 9 grams. The last time she was seen in the clinic of the Children's Hospital was in 1937, at which time she was still having occasional attacks of recurrent abdominal pain and the low hemoglobin level of 9 grams.

The family history is best summarized in the chart of the family tree (Fig. 1), prepared through the courtesy of Dr. James V. Neel of the Department of Human Heredity of the University of Michigan. From this chart it is noted that although nine individuals in her family possessed the sickle-cell trait, our patient is the only one with true sickle-cell anemia. It is regrettable that her father died in 1927 because blood studies on him would have been of inestimable value.

Physical Examination.—Height, 67 inches; weight, 108½ lbs.; temperature, 99°; pulse, 96; blood pressure, 110/70. The patient was an extremely thin, asthenic Negro female with the typical spindly legs seen in patients with sickle-cell anemia. The sclerae were markedly jaundiced. The heart was not enlarged to percussion, but a soft blowing apical systolic murmur could be heard. There was no axillary transmission of the murmur. The lungs were clear and resonant throughout. The liver edge, which was sharp and the surface of which was smooth, could be felt four to five finger-breaths below the right costal margin in the right mid-clavicular line. There was moderate tenderness of the liver on palpation. A well-healed T-shaped scar from the aforementioned splenectomy was seen in the left upper quadrant of the abdomen. The uterus was slightly larger than normal and the cervix was softened. The lower extremities showed scars of old ulcerations over the lower one-third of the tibial surfaces. The neurological examination was essentially negative. The laboratory data are summarized in Table I.

Clinical Course.—The patient was placed on a high carbohydrate, high protein, low fat diet with a supplement of at least two quarts of milk a day. She was also given choline dihydrogen citrate, 10 grains three times a

From the Department of Internal Medicine, North End Clinic, Detroit.

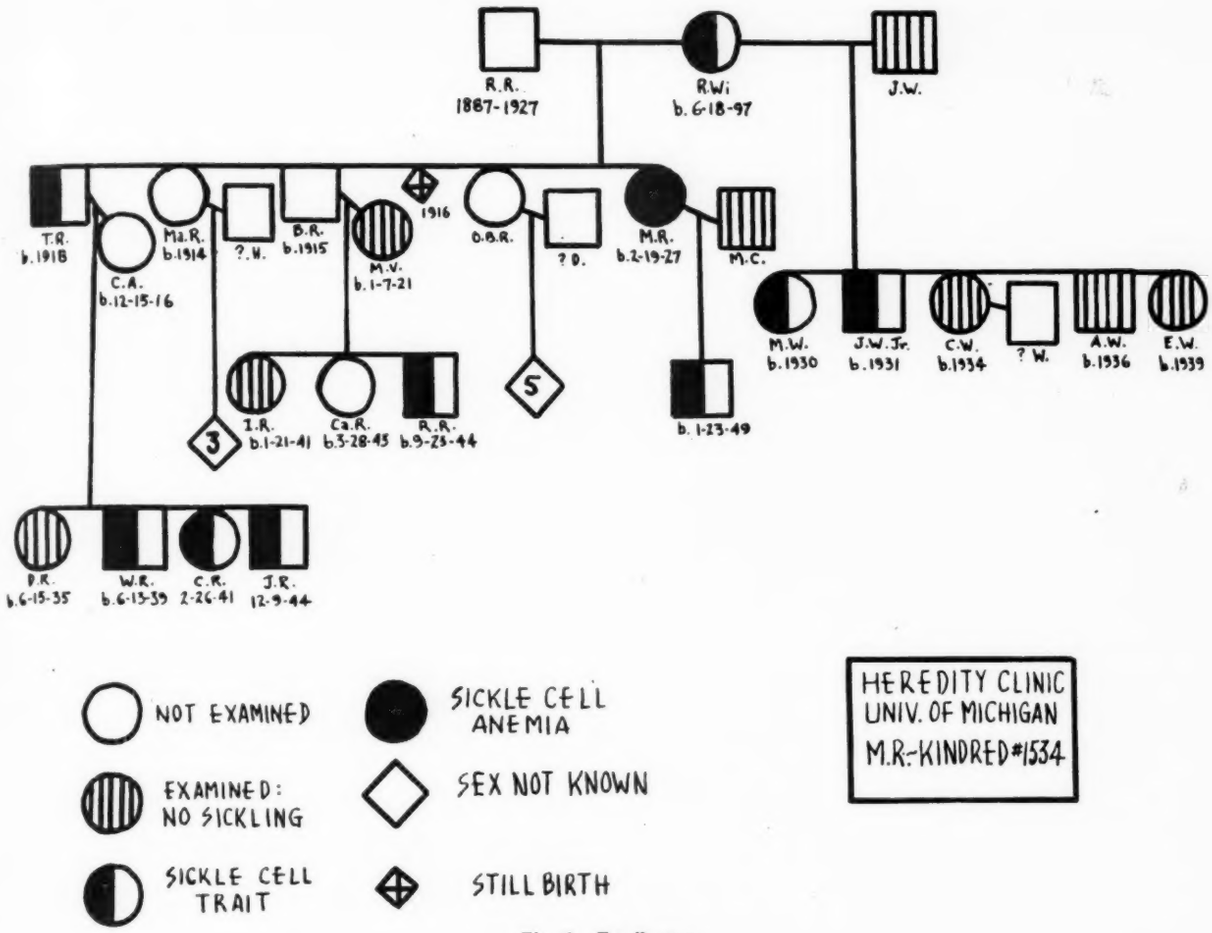

Fig. 1. Family tree

TABLE I. LABORATORY FINDINGS FROM NORTH END CLINIC

Date	*Laboratory Data*
5-25-48	Kahn negative. Urinalysis: Reaction acid; sp. gr. 1.013; albumin negative; sugar negative.
6-7-48	Hgb. 56%; RBC 3.00 million; WBC 10,000. Diff.: neutrophiles 78%; lymphs. 21%; eosinophiles 1%. Has 50% sickling of RBC on counting chamber. Icterus index: 31 units. Vanden Bergh: direct 10 min.-0.85 mg. direct 30 min.-2.05 mg. indirect 2.5 mg. Cephalin—cholesterol flocculation test; slight trace after 48 hours. Urobilinogen in urine; Postive 1:20.
6-22-48	Icterus index 23.5 units. Hgb. 48%; RBC 3.40 million; WBC 12,500. Diff.: neutrophiles 70%; lymphocytes 29%; eosinophiles 1%. Marked anisocytosis and poikilocytosis. Many sickle cells. Urine negative for bile.
8-24-48	Hgb. 60%; RBC 2.49 million; WBC 10,700. Neutrophiles 68%; lymphocytes 26%; monocytes 4%; eosinophiles 1%; basophiles 1%; marked anisocytosis, macrocytosis; sickle cells, hypochromasia. There are 7 nucleated red cells seen in a count of 100 WBC's. Icterus index: 31 units.
9-8-48	Hgb. 67%; RBC 3.27 million; WBC 10,450. Neutrophiles 82%; lymphocytes 15%; monocytes 3%. There are 6 normoblasts per 100 WBC. Red cells show anisocytosis and sickling. Icterus index: 23.5 units.
10-20-48	Hgb 58%; RBC 2.64 million; WBC 18,650. Neutrophiles 82%; lymphocytes 17%; eosinophiles 1%. There are 13 normoblasts per 100 WBC. Many sickle cells and other bizarre shaped red cells.
3-8-49	Hgb 52%; RBC 3.48 million; WBC 14,400. Neutrophiles 46%; lymphocytes 46%; monocytes 4%; eosinophiles 4%. Sickle cells, anisocytosis, poikilocytosis, hypochromasia seen on stained smear.

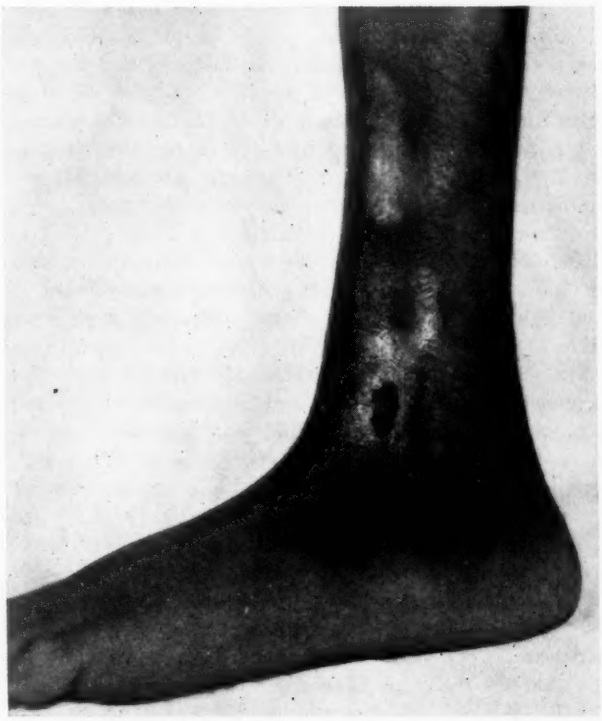

Fig. 2. Fresh ulceration of left ankle typical of sickle-cell anemia. There are scars of old ulceration seen more superiorly on the leg.

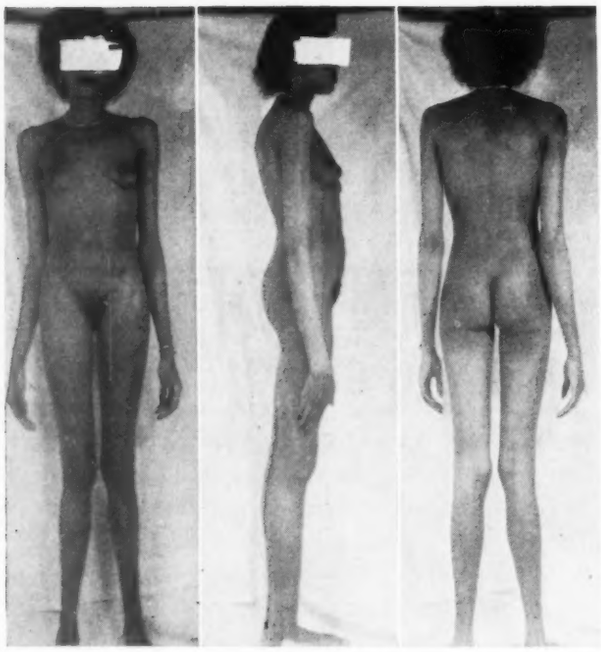

Fig. 3. Patient as seen post partum. Photographs show the typical spindly legs and asthenic habitus frequently seen in sickle-cell anemia.

day. A course of ferrous sulfate and liver extract was given with no apparent effect on the blood picture. The patient was seen weekly at North End Clinic, and on June 29, 1948, she was admitted to the Wayne County General Hospital because of the extremely low hemoglobin of 48 per cent. There she was given several blood transfusions, with general improvement in subjective feeling but no great improvement in her anemia. The laboratory data obtained at the Wayne County General Hospital are summarized in Table II. Meanwhile the pregnancy was progressing satisfactorily and the patient was being seen in the prenatal clinic of the Herman Kiefer Hospital, Detroit (Table III). The patient began to gain weight, and by October 12, 1948, it was noted that she had gained 5 pounds. During that examination the fetal heart tones could be heard. On November 16, 1948, after having had a 1,000 c.c. blood transfusion the patient felt much improved and weighed 121 pounds. The fetal heart tones were again heard at that examination and the fetal movements were very active. On January 23, 1949, the patient went into labor and was admitted to the Herman Kiefer Hospital where she was delivered of a male child weighing 3 pounds 12 ounces. The child was treated as a premature baby and upon discharge January 29, 1949, weighed 5 pounds 4 ounces and his general condition was good. On March 8, 1949, the patient's baby was examined and found to be healthy and active, and blood studies were done on the child. The hemoglobin was 12.4 grams and the sickling preparations were all positive, although the maximum of sickling in any preparation was 13 per cent. Dr. Neel made these studies and felt that on the basis of a more or less normal hemoglobin level and the observed low percentage of sickling that the baby probably has the sickle-cell trait rather than sickle-cell anemia.

TABLE II. FINDINGS AT WAYNE COUNTY GENERAL HOSPITAL

Date	*Laboratory Data*
	Blood Count
7-15-48	Hgb. 9.5; RBC 2,440,000; WBC 10,950; PMN 55, N 53, NF 2, L 36, M 7, B 2; two metamyelocytes. Many sickle cells.
7-19-48	Hgb. 9.7; RBC 3,270,000; WBC 24,150; PMN 78, N 66, NF 12, L 15, M 5, and E 2. Reticulocytes 6.0. Sickles.
7-21-48	Hgb. 7.5; RBC 2,540,000; WBC 15,100; PMN 67, N 65, NF 2, L 20, M 5, E 5, B 3. Reticulocytes 4.5.
7-23-48	Hgb. 9.3; RBC 3,240,000; WBC 23,850; PMN 63, N 55, NF 8, L 25, M 8, E 1, B 3; many sickle cells; poikilocytosis, moderate anisocytosis. Reticulocytes 2.8.
7-24-48	Hgb. 9.3; RBC 3,440,000; WBC 21,100; PMN 76, N 68, NF 8, L 20, M 4.
7-26-448	Hgb. 9.3; RBC 3,420,000; WBC 21,100; PMN 62, N 52, NF 10, L 24, M 11, E 1, B 2. Reticulocytes 6.8. Sickle cells.
7-29-48	Hgb. 8.3; RBC 2,780,000; WBC 17,950; PMN 65, N 63, NF 2, L 25, M 5, E 4, B 1. Reticulocytes 6.2. Sickle cells.
	Urinalysis
7-15-48	SG 1.007; negative sugar and albumin; microscopic SBC 1—3.
7-20-48	Negative sugar and albumin; microscopic WBC 2—4 and no RBC.
	Blood NPN
7-17-48	43.
	Chemistry
7-19-48	Van den Bergh immediate direct; bilirubin 6.2; Thymol turb. 3.5; thymol flocc. trace; cephalin flocc. 2 plus.
7-27-48	Van den Bergh immediate direct; bilirubin 2.6.
7-30-48	Total protein 7.6, serum albumin 3.4, serum globulin 4.2; Van den Bergh immediate direct; bilirubin 2.1; cephalin flocc. negative.
	Serology
7-17-48	Negative Kline exclusion.
	Vagina
7-24-48	Hanging drop—no Trichomonas.
	Cervix
7-24-48	Smear—occasional pus cell; Gram-postive baccilli; Gram-negative baccilli; no Gram-negative intracellular diplococci. Culture—no growth of N. gonorrhea in two days.

TABLE III. FINDINGS AT HERMAN KIEFER HOSPITAL

Date	*Laboratory Data*
9-8-48	RBC 2,880,000; Hgb. 58%. Appearance of RBC suggests sickle-cell anemia. Weight 110½ pounds B.P. 108/68
9-22-48	RBC 2,670,000; Hgb. 62%. Sickle cell found.
11-1-48	Admitted to Herman Kiefer Hospital. RBC 2,700,000; Hgb. 58%; Hematocrit 28%. 1000 c.c. whole blood given.
11-3-48	Icterus index 27.2; 500 c.c. blood given.
11-4-48	RBC 3,590,000; Hgb. 75%; Hematocrit 38.5%.
11-5-48	Discharged.
12-16-48	Re-admitted to Herman Kiefer Hospital.
12-17-48	RBC 2,210,000; Hgb. 40%; Hematocrit 22%.
12-18-48	500 c.c whole blood given.
12-20-48	Icterus index 15.5; 500 c.c. whole blood given.
12-21-48	Discharged.
1-14-49	Re-admitted to Herman Kiefer Hospital.
1-15-49	RBC 2,400,000; Hgb. 65%; WBC 11,725. History revealed that the North End Clinic diagnosed anemia on this patient in April, 1948.
1-16-49	Discharged. Undelivered.
1-18-49	Re-admitted.
1-23-49	Delivered male child, 3 lbs. 12 oz.
1-24-49	RBC 2,170,000; Hgb. 44%; WBC 19,900.
1-28-49	RBC 2,580,000; Hgb. 34%; WBC 26,550.
1-29-49	Discharged. Melvin (baby) weight 5 lbs. 4 oz.

Discussion

It can be seen from the diagram of the family tree that there is a "biologic dilution" of sickle-cell anemia. From these data it may be speculated that eventually sickle-cell anemia may be bred out of the Negro race, because of this dilution

(Continued on Page 1530)

Protective Sterilization in Michigan

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DECREASING the number of children born to feebleminded parents each year, many of them inheriting the mental handicap of their parents, may be likened to controlling an epidemic. While the offspring of defective parents are not all subnormal, the proportion of retarded children is high, and many of the children will in turn bear defective offspring. Moreover, all the children will be raised under the unsatisfactory upbringing of a feebleminded parent. To a lesser degree the same disadvantages pertain to the descendants of the insane.

Selective sterilization has long been advocated as a means of controlling this perpetuation of mental abnormalities. Careful follow-up of cases has shown that the sacrifice involved is minimal. Tubectomy of the ovarian and spermatic tubes interferes with no function of the body other than the capacity for parenthood. There is no decrease in sexual activity, and libido is not diminished. Since the psychic and economic capacities of the mentally defective person are distinctly reduced, protection from the additional burden entailed by parenthood is especially valuable both to the patient and to the community.

To make the protection of sterilization available at governmental expense to patients in state institutions, laws have been passed by a number of states. The first to employ it as a public health procedure was Indiana whose eugenic sterilization law was passed in 1907. The constitutionality of such a law was assured by a test case carried to the United States Supreme Court by the heads of state mental institutions in Virginia. The decision ended with the pertinent and now well-known phrase: "Three generations of imbeciles are enough."

Michigan's first sterilization law, passed in 1913, was declared unconstitutional by the State Supreme Court in 1918. A new law applying to the mentally deficient was enacted in 1923 to eliminate the legal and constitutional weaknesses of its predecessor. In 1925 it was amended, giving the court authority for ordering the operation. The law was contested in 1925 and 1926 and upheld as constitutional in both cases.

In 1929 a new law was passed which included insane and epileptic persons as well as the feebleminded.[1] Its constitutionality has not been contested. The law provides that whenever the superintendent of a state institution for the insane or the feebleminded shall be of the opinion that any inmate is likely to procreate children unless closely confined or rendered incapable of doing so, that such children would have a tendency to insanity or mental defectiveness, and that there is no probability that the condition of the person will improve, he shall notify the State Hospital Commission. With the written consent of the patient, his guardian and a close relative, sterilization may be done at state expense by x-rays, vasectomy or salpingectomy. Sterilization without such consent is rarely done, though the law provides that it can be after approval by the probate court and an examination by two physicians whom the court appoints.

Petitions for sterilization may also be presented to the probate court by close relatives or the guardian of a mentally abnormal person or by a superintendent of the poor or supervisor of a township. The law provides for appeal to the higher courts if the patient is not satisfied with the decision.

Statistics collected by the Human Betterment Foundation of California and Birthright, Inc.,[2] give the number of sterilizations under these laws reported by state institutions. They show that Michigan had reported a total of 2,851 operations at the end of 1947. This number is exceeded only by California with 18,716, Virginia with 5,232, and Kansas with 2,983.

For comparisons among the states, population should be taken into account. The sterilization rates per 100,000 inhabitants have, therefore, been calculated and are given in Table I and Figure 1. Michigan, with a total of 46 per 100,000 is seventeenth among the twenty-seven states which have sterilization laws. The average for these states is 81. The 117 persons operated on in 1947, amounted to 1.9, giving Michigan eleventh place. To smooth out the variations from year to year, the rates for the five years, 1943 to 1947 inclusive, have also been calculated. Michigan, with 1.6 per 100,000, occupies fifteenth place. The maxi-

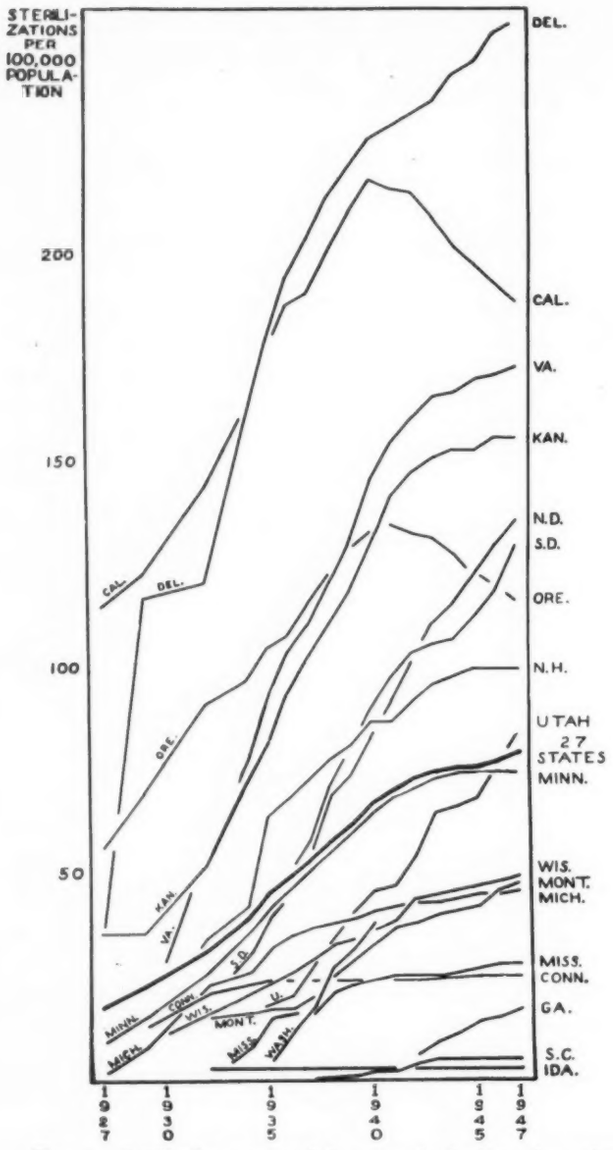

Fig. 1. Sterilizations reported by state institutions since the passage of the sterilization laws (cumulative figures). The broad line indicates the average values for the twenty-seven states having sterilization laws. The decrease in some of the curves results from a growth of population more rapid than the increase in the total number of sterilizations. Populations interpolated from censuses of 1930 and 1940 and estimate for 1947.

mum activity was during 1935, when 316 persons were protected.

Estimates of the prevalence of feeblemindedness have varied, but if the conservative value of 1 per cent is used, there are 62,500 feebleminded persons in Michigan. This is twenty-seven times the 2,290 feebleminded persons who have been protected from parenthood. The assumption that the mentally deficient live, on the average, fifty years indicates that there are at least 1,250 new cases added to this group each year. The 100 tubectomies for mental deficiency in 1947 are less than 1 in 12 of these.

TABLE I. STERILIZATIONS REPORTED BY STATE INSTITUTIONS PER 100,000 POPULATION

Compiled from the reports of the Human Betterment Foundation and of Birthright, Inc.

Total Sterilizations to Jan. 1, 1948		Sterilizations per Year 1943-1947		1947	
Del.	256	Del.	7.6	Utah	9.1*
Cal.	189	Utah	6.9	S. D.	8.2*
Va.	173	Va.	5.2	Del.	5.1
Kan.	156	Cal.	4.8	Cal.	4.1
N. D.	136	N. D.	4.3	Va.	4.0
S. D.	130	N. C.	3.4	N. C.	3.7*
Ore.	117	S. D.	3.1	N. D.	3.1
N. H.	100	Ind.	3.0	Iowa	2.7*
Utah	85	Kan.	2.9	Ind.	2.3
Minn.	76	N. H.	2.9	Ore.	1.9
Vt.	69	Ore.	2.6	Mich.	1.9*
N. C.	53	Ga.	2.2	Kan.	1.5
Neb.	51	Neb.	2.1	Mont.	1.2*
Wis.	49	Iowa	2.1	N. H.	1.1
Mont.	48	Mich.	1.6	Wis.	1.1
Ind.	46	Vt.	1.4	Ga.	0.7
Mich.	46	Wis.	1.3	Neb.	0.5
Iowa	29	Mont.	1.1	Miss.	0.5
Miss.	28	Minn.	0.7	Me.	0.3
Me.	25	Miss.	0.5	Conn.	0.3
Conn.	25	Conn.	0.4	Minn.	0.03
Okla.	24	Me.	0.3		
Ga.	17	S. C.	0.2		
S. C.	4	W. Va.	0.01		
Ariz.	3				
Ida.	3				
W. Va.	3				
Average for 27 states having sterilization laws	81		2.3		2.1

Populations interpolated from U. S. Census for 1940 and estimate for 1947.

*1947 rate greater than 1943-1947.

An adequate program for the sterilization of the psychotic patient is more difficult to estimate, as many cases, due to age or the mildness of the disease, do not need protection. Reports for 1943 to 1946, the most recent years for which they are available, show that the annual average of first admissions with psychosis to Michigan state hospitals was 2,764, and of deaths, 1,461. The difference of 1,303 will, in the long run, equal the number of first discharges with psychosis. This is 109 times the twelve tubectomies performed on psychotics in 1947. It seems probable that protection would have been appropriate for a larger proportion.

The average physician is confronted with few cases of psychosis or mental deficiency. He is apt to transfer those that do come to him to specialists or state institutions. Each doctor, however, can do much to protect the mentally handicapped and their potential offspring. If he will enlighten the patients in his practice regarding sterilization, explaining to them that the only change in normal

(Continued on Page 1490)

Diagnosis and Surgical Treatment of Deafness

By James E. Croushore, M.D.
Detroit, Michigan

BEFORE TREATMENT is advised or instituted in any case of deafness, the deafness must be classified. The classification is made by the history, objective examination and the hearing tests. Hearing tests for classification are done both with the audiometer and tuning forks.

In order to understand just where the various types of deafness fit into the general heading of hearing defects, the following classification of deafness is offered:

1. Nerve (perceptive) deafness.
2. Conductive (obstructive) deafness.
   (a) Obstruction of external canal: congenital atresia, cerumen, exostosis, furuncles, et cetera.
   (b) Middle ear disease: otitis media, tubotympanitis, et cetera.
   (c) Otosclerosis.

In nerve deafness, the bone conduction is down and the ability to hear high-pitched tones is first lost. In conductive deafness, the bone conduction is normal or increased, and the ability to hear low-pitched tones is first lost. A diagnosis of otosclerosis is justified if a conductive deafness is present in an individual who gives a negative history of ear infections and the objective examination is negative. One must be aware that a combination of factors may be present, resulting in a mixed deafness.

There is no effective treatment for nerve deafness. Fortunately, much can be done for the prevention and improvement of conductive deafness. The eradication of middle ear disease, removal of enlarged and septic tonsils and adenoids, and the application of radium to the orifices of the eustachian tubes will frequently be of value.

Otosclerosis is a new osseous formation affecting primarily the bony capsule of the labyrinth. In the early stages of the disease, the cartilaginous remnants which are normally found in the otic labyrinth are replaced by spongy bone. This spongy bone slowly scleroses and the progression of the otosclerosing process results in a thickening of the otic capsule. Since the disease usually starts in the region of the oval window, into which the foot plate of the stapes fits, there occurs a fixation or ankylosis of the stapes. The ankylosis of the stapes prevents its free vibration so that sound waves are not transmitted into the inner ear. Naturally, the hearing acuity is diminished and the individual becomes aware that the hearing is being lost. The cause of otosclerosis has not been definitely established.

The amount of deafness produced by otosclerosis is proportional to the degree of fixation of the stapes. After a period of years, there develops a secondary nerve deafness, probably resulting from atrophy of disuse, or it may be a part of the process. For the fenestration operation to be of any value, it must be performed before the nerve degeneration becomes advanced. It would be useless to have sound waves reach the inner ear if they could not be transmitted to the brain where they are interpreted as sound.

An individual with otosclerosis must fulfill certain requirements in order to be a favorable candidate for the fenestration operation. The general health must be good. Mild diabetics who are easily controlled can safely be operated. The ideal age is the twenty- to forty-year group. People over fifty-five probably should not be operated upon. The extreme age limits the writer knows of are a woman over sixty years and a child of eight, who were operated upon and both obtained very good results. There should be a negative history of ear infections, or if otitis media has been present in earlier years, there should be no evidence of residual infection. The hearing loss should be at least 40 decibels. The patient should have a good understanding of just what is entailed in the operative procedure and have an open mind about all possible factors that may arise. With this knowledge, the patient must be willing to submit to an entirely elective surgical operation.

What benefits can the patient expect from the operation? Statistics reported by various operators in several sections of the country reveal that approximately 70 per cent recover permanent practical hearing for the average conversational voice. Also, the annoying tinnitus disappears in almost all ears operated upon. Sound is natural, whereas with a hearing aid it is artificial. In order to receive practical hearing, the improvement must rise to or above the 30 decibel level.

Presented at the third annual Postgraduate Clinical Institute, Detroit, Michigan, March 23, 1949.

Patients who are awake when the fenestra is made will hear instantaneously. But since most of them are asleep and the cavity is packed for six days, they are not aware of improvement. The hearing should return in two to six weeks as that much time is required for operative reaction to subside and permit the flap to transmit sound waves. Dizziness is an annoying factor for about ten days postoperatively. The dizziness is proportional to the amount of postoperative labyrinthitis.

A certain percentage of the openings will close by new bone formation within a year. There is much evidence that if the fenestra remains open for a year, it will almost certainly remain open permanently.

The fenestration operation is the only treatment for deafness due to otosclerosis that is of any value. Passow in Germany in 1896 first made an opening into the labyrinth with hearing improvement which lasted only a few days.

Jenkins in England and Barany in Vienna made contributions to the operation. Holmgren in Sweden further improved the technique and obtained better results. Sourdille in France worked on it from 1924 to 1937 and elaborated a complicated three- or four-stage operation. He was the first to have a window remain open for five years. Lempert of New York first published his technique in 1938. Lempert combined Sourdille's multiple-stage procedures into a practical one-stage operation. In 1941 Lempert described the "fenestra nov-ovalis" which is the technique used today by the operators doing the operation.

Some operators use local anesthesia combined with deep narcosis. This is the anesthesia used at Harper. Various combinations of local and general anesthesia have been worked out by different individuals. The operation usually requires from two to four hours; thus, it is essential that the safest and least shocking type of anesthesia be employed.

The technique developed by Lempert employs the endaural approach. By a combination of three incisions, or a single incision, where the auricle joins the external canal, the auricle can be mobilized and the mastoid cortex exposed. With an electrically driven dental bur and specially designed curettes, the cortex and mastoid cells are removed and the semicircular canals skeletonized. The posterior bony canal is then removed with special small rongeurs, care being taken not to tear the membranous canal or ear drum. The skin of the posterior canal is now incised and reflected posteriorly. This skin flap is continuous with the ear drum and is a marked improvement over a skin graft as the flap retains a blood supply. The incus and the head and neck of the malleus are removed so the flap may lie flat over the fenestra. At this point a magnifying loupe or dissecting microscope is now employed while the opening is being made into the anterior aspect of the horizontal semicircular canal with a finishing bur. The most exacting care is necessary while making the fenestra in order not to injure the facial nerve or the delicate membranous inner ear. Even by gently touching the membranous labyrinth, it may be ruptured and the endolymph escape, producing complete and permanent deafness.

MSMS

PROTECTIVE STERILIZATION IN MICHIGAN

(Continued from Page 1488)

functions is the desired one that no children are produced, the needed consent of the mentally abnormal and his family will be much more easily secured.

References

1. Michigan Laws, 1929, No. 281; Compiled Laws, Secs. 6646 to 6653.
2. Publication No. 5, Birthright, Inc. 134 Nassau St., Princeton, New Jersey, 1948.

ON THE RUN . . . . . .

Normally, restraint of automatic arm-swinging on one side reinforces arm-swinging on the opposite side. In unilateral pyramidal lesions such restraint is not thus effective, whereas in extrapyramidal lesions the opposite arm-swinging occurs if there is not much hypertonus.

* * *

Subcutaneous granulomata from beryllium may occur in those who cut themselves on broken fluorescent lamps.

* * *

The use of the handkerchief is, next to bed-making, one of the most important actions in contamination of the air with micro-organisms from the respiratory tract.

* * *

In a heart with tissue respiration impaired by myocardial damage, a full stomach elicits reflex coronary constriction with dangerous anoxemia.

* * *

In providing medical care for people over 65, it must be assumed that at least half will have some chronic disease.

Selected by R. S. Reveno, M.D.

Detroit Physiological Society

Meeting of October 29, 1949

Staphylokinase: A Proteolytic Enzyme Activator

EARL B. GERHEIM

From the Department of Physiology and Pharmacology, Wayne University College of Medicine, Detroit

Among the tests used to determine the pathogenicity of *staphylococcus aureus* strains are the "coagulase" test and the demonstration of proteolytic activity. The mechanism for these reactions has not been too clearly defined in the past. One of the explanations for these phenomena was that the "coagulase" is a proteolytic enzyme which in a low concentration caused clotting, and lysis if the concentration was increased. Heat liability studies have clearly shown this is not true. The mechanism for the proteolytic activity is analogous to the action of *streptokinase,* namely, a bacterial kinase activates a proenzyme found in plasma. A comparison of the specificity of *streptokinase* and *staphylokinase* indicates a dissimilarity. While the former activates a proenzyme found in human plasma (or serum) the latter serves as an activator for the proenzyme in dog and rabbit plasma. In addition, these two bacterial factors differ in the rate of maximal enzyme development; *streptokinase* acts almost immediately but the *staphylokinase* takes a fifteen to thirty-minute incubation period.

* * *

Transamination in Nutritional Muscular Dystrophy

DANIEL H. BASINSKI

Children's Fund of Michigan

The aspartic-glutamic transaminase activity of skeletal muscle homogenates from vitamin E-deprived rabbits and guinea-pigs was measured and found to be appreciably lower than that of normal control animals. The decrease of activity was consistent whether it was calculated on the basis of wet or dry weight of tissue or on the total nitrogen content of the tissue. That loss of transaminating coenzyme was not a factor in diminshed enzyme activity was demonstrated by the lack of effect when pyridoxal phosphate was added to the system. The possibility that the lowered rate of transamination in dystrophic muscle was an artifact brought about by an enhanced destruction of oxaloacetic acid by dystrophic muscle *brei* was ruled out by recovery experiments which showed that on the contrary, normal muscle *brei* caused a greater loss of excess oxaloacetate.

The significance of these results in the altered energy metabolism of dystrophic muscle was discussed.

* * *

Changes in Plasma Volume and Circulating Proteins Following the Removal of Ascitic Fluid in Laennec's Cirrhosis

GLENN I. HILLER, E. R. HUFFMAN AND STANLEY LEVEY

Wayne County General Hospital and Wayne University

Changes in plasma volume (T-1824) and total circulating proteins were investigated, in seven instances, before, immediately after, and eight hours following the complete removal of ascitic fluid from five patients with advanced Laennec's cirrhosis.

In each instance, immediately following removal of the ascitic fluid, the plasma volume, total circulating protein and total circulating globulin fell, the maximum fall being 25, 29 and 31 per cent, respectively, of the control values. In four instances, there was an appreciable increase in total circulating albumin. Serum protein concentrations varied from the control values but followed no consistent pattern.

Eight hours later, the plasma volume was elevated in five and lowered in two instances, the maximum deviations from the control values being 22.9 and 10.3 per cent, respectively. At this time, in most instances, the total circulating protein and the total circulating globulin were appreciably lowered. In four instances, the total circulating albumin was higher, the maximum increase being 56.8 per cent. Concentrations of the serum proteins at the eight-hour period varied from the control values but followed no consistent pattern.

These data offer an explanation for the periph-

(Continued on Page 1534)

FRANZ G. ALEXANDER, M.D.
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Rochester, Minnesota

WM. L. BENEDICT, M.D.
Rochester, Minnesota

MARION A. BLANKENHORN, M.D.
Cincinnati, Ohio

Michigan Postgraduate Clinical Institute

March 8-9-10, 1950

Book-Cadillac Hotel — Detroit

Some of the
Thirty-nine Guest Speakers
on the Institute Program

F. BAYARD CARTER, M.D.
Durham, North Carolina

GEORGE CRILE, JR., M.D.
Cleveland, Ohio

RICHARD H. FREYBERG, M.D.
New York City

J. MASON HUNDLEY, JR., M.D.
Baltimore, Maryland

JULIAN P. PRICE, M.D.
Florence, South Carolina

LEO G. RIGLER, M.D.
Minneapolis, Minnesota

FRANCIS E. SENEAR, M.D.
Chicago, Illinois

I. SNAPPER, M.D.
New York City

WALTMAN WALTERS, M.D.
Rochester, Minnesota

One's Fellow Man

The approaching year-end in the merchandising world is at once a period of assessment, intense current business activity and planning. The earnings of the previous months and quarters have been accumulated and must be evaluated in terms of planning for the forthcoming year. Nevertheless, the Christmas shopping rush remains, and the year-end clearance sales of stocks that have not moved are still to be organized.

It is of interest to consider that the doctor, too, is a merchandiser of sorts. True, he is disbursing services and counsel rather than material goods. But the parallel exists, and he might well note the example of his business colleagues. There will inevitably be a few medical practices and theories that have not "moved," and had best be marked for clearance. Medical change is too pronounced for it to be otherwise, and there is no room in modern medicine for the doctor who is unwilling to improve his "stock." The earnings of the previous quarters can be evaluated, not in terms of dollars and cents nor according to the chrome on the present car, but rather in terms of the inner satisfaction of a job well done. The "sales appeal" of the medical profession collectively merits more than a passing glance. Are the people of the community generally aware of medical problems and necessities and are they convinced of the sincerity of their doctors?

As a basis for planning the program of the forthcoming year—and a thought for the Christmas Season too, if you will—the physician could consider the purpose, the raison d'etre, of a medical practice. No one among us has time to waste on sentimentality concerning the human service aspects of a doctor's life. But one cannot practice sound medicine without remembering that his subject, in the final analysis, is not a mere collection of disassociated symptoms and scientific facts, but rather is one's fellow man, his physical and spiritual well being, his occupations and aspirations, and his human frailties.

W. E. Barstow M.D.

President, Michigan State Medical Society

President's

Page

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

The Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan

NEW COURSE ON CANCER—January 17-20, 1950

Registration: Tuesday, January 17, 1950—8:00-8:45 A.M., Room 2040, University Hospital

Introduction: 8:45-9:00 A.M. Introduction by Dr. H. H. Cummings

HOUR	TUESDAY—Jan. 17	WEDNESDAY—Jan. 18	THURSDAY—Jan. 19	FRIDAY—Jan. 20
A.M. 9:00 to 10:00	The nature, biology, genesis and implications of cancer. Dr. Carl V. Weller	Cancer of skin Dr. Arthur C. Curtis	Cancer of breast Dr. Frederick A. Coller	Cancer of cervix Dr. Norman F. Miller
10:00 to 11:00	Pathology of cancer of lung, bronchi and mediastinum. Dr. Weller	Pathology of cancer of stomach and bowel. Dr. R. C. Wanstrom	Pathology of cancer of prostate and bladder Dr. C. C. Congdon	Pathology. Cancer in childhood Dr. A. C. Upton
11:00 to 12:00	Clinic: (Sections) A: Thoracic Surgery B: Medicine C: Urology D: Pediatrics	Clinic: (Sections) A: Medicine B: Urology C: Pediatrics D: Thoracic Surgery	Clinic: (Sections) A: Urology B: Pediatrics C: Thoracic Surgery D: Medicine	Clinic: (Sections) A: Pediatrics B: Thoracic Surgery C: Medicine D: Urology
P.M. 1:30 to 2:45	Clinic: (Sections) A: Thoracic Surgery B: Medicine C: Urology D: Pediatrics 2:45 to 3:15 Intermission	Clinic: (Sections) A: Medicine B: Urology C: Pediatrics D: Thoracic Surgery	Clinic: (Sections) A: Urology B: Pediatrics C: Thoracic Surgery D: Medicine	Clinic: (Sections) A: Pediatrics B: Thoracic Surgery C: Medicine D: Urology
3:15 to 4:30	Seminar (entire class) Thoracic Surgery Roentgenology Pathology Chairman: Dr. Alexander	Seminar (entire class) Medicine & Surgery Roentgenology Pathology Chairmen: Drs. Coller & Pollard	Seminar (entire class) Urology Roentgenology Pathology Chairman: Dr. Nesbit	Seminar (entire class) Pediatrics Surgery Roentgenology Pathology Chairman: Dr. Wilson
6:00	Friday evening, January 20. Dinner and discussion period. Allenel hotel.			

THIS IS THE SECOND POSTGRADUATE COURSE TO BE OFFERED AS A PART OF THE PROGRAM OF ACCENTUATED CANCER TEACHING AT THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL. Registration limited to 24 Michigan physicians. Fee $25.00. Application for enrollment should be made to Dr. H. H. Cummings, Chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

Editorial

THE WELFARE STATE

THE MODERN ideas of a Welfare State are a condition in which almost everybody expects to be taken care of, to be made secure. The State is one's guardian. One does not need to worry about the present or the future, the State will look after him and will provide for his needs. Such a State always starts with making provision of a few items for everybody, and ends up with many, or all his requirements. Some nations in Europe at the present time are shining examples of what may occur.

The term "Welfare State," as we have known it, represents a condition which we fear—socialism. Americans have always been rugged individualists, have been able and proud to look after themselves. Recently we are hearing a different interpretation of the Welfare State. A campaign is just concluded in New York, looking to the election of a United States Senator in which the Welfare State has been a main issue. One side abhored the idea as being something foreign to American ideals; the other side has praised the Welfare State as being something desirable, something which our people need.

Senator Hubert H. Humphrey, Junior Senator from Minnesota, in a discussion over the Town Meeting of the Air Tuesday evening, November 1, praised the Welfare State as being an attempt to live up to the provisions of our Constitution, which says a function of Government is "to provide for the general welfare." Others in the Administration —Ewing, Truman, Pepper—have praised the Welfare State as the Washington bureaucrats see it. Is this a movement stimulated by politicians and would-be office holders to befuddle the minds of our people so that in accepting the provisions of modern socialism, which they are teaching, it would seem that the purposes of our Constitution are being fulfilled?*

The proposed Welfare State, if carried to a logical conclusion, would give control of our very lives and existence to office holders and bureaucrats. Socialized medicine is just one feature of this program. We are vitally interested in that, but we are just as profoundly interested in the whole picture.

*Senator Humphrey's subsequent statements regarding voluntary insurance belie his complete belief in the Welfare State.

POLICE STATE

A YEAR AGO it was our duty to report the indictment of the Oregon State Medical Society, the Oregon Physicians Service, and others, by the Attorney General of the United States on the charge of conspiracy. The allegation was that these organizations and doctors in Oregon were conducting a monopoly in their effort to provide good medical and hospital service for their patients on a prepayment basis. At that time, there was threat of another suit in California, and we were hearing rumors of investigation in the East and in Michigan. We believed then, as we do now, that this was a part of a studied program from Washington to vilify the medical profession; to make the medical profession look ridiculous in the eyes of the general public; to give the impression to the casual observer that the medical profession must have very serious shortcomings if it were guilty of things calling for investigation and punishment by the Justice Department.

In our June JOURNAL this year, we made some comments upon this same general topic. News broke early in October, 1949, that the FBI had been visiting the offices of twenty-two medical societies and organizations to investigate the records. The American Medical Association's Board of Trustees announced that somebody (could it have been the FBI?) broke into the Board Room of the American Medical Association in February. Late in October the FBI agents were still at work in the American Medical Association offices, going over all records.

On October 6, an FBI special agent entered the headquarters office of the Michigan State Medical Society and demanded to see all of our records back to 1934. He submitted a letter, *dated August 25, 1949,* requesting permission to review the records of the Society for "investigation of alleged violations of the Federal Anti-Trust Laws in the medical fields." Full access was given to all minutes and records in the office. None was removed from the office. The FBI agents also visited Michigan Medical Service in Detroit, looking for anything which they might use to our disadvantage.

Has the Federal Government converted itself

into a police state? This comes suspiciously soon after the President's Reorganization Plan No. 1 was defeated. That plan, as our members all know, would have put Oscar Ewing in the Cabinet in charge of all health services. We feared it would mean the end of an independent progressive medical profession and the beginning of the medical chaos which is now rampaging in Great Britain. We opposed the Reorganization Plan and succeeded in getting it rejected by the Senate because it was not in conformity with the Hoover Commission recommendations for a United Medical Administration independent of the Department of Welfare. This present investigation has the earmarks of a reprisal measure.

That we have gone a long way down the road of police statism is manifested by a consideration of some regulations now in effect. Many of us have sons or daughters and their families in Germany now in connection with the rehabilitation program. Most of them went over under the auspices of the Army, but in the recent reshifting are now under the direct control of the State Department. That program is of great value, and most decidedly needed, but do you know the terms of service in Germany? These young American citizens may write letters home to their families, but those letters cannot be distributed beyond the family, they must not be published or distributed unless *they have been censored and approved by the FBI* in Germany. We call that a fair degree of police state, and we believe the American people should understand the situation.

DUTY OF THE AMERICAN MEDICAL ASSOCIATION

THE PLETHORA of investigations by the Federal Government, and its police, the FBI, causes us to ponder where this campaign will end. Anyone with half an eye could foresee this gamut of investigations. The Michigan Delegates to the House of Delegates of the American Medical Association saw clearly what was coming and at the annual session at Atlantic City in July offered a resolution to the effect that the AMA accept any such indictment of any State Medical Society as an indictment of itself; that it declare itself in on any such action; and that it make every resource of the American Medical Association available for the complete defense of such action.

The Resolution met the approval of many of the degelations from other states, but at the specific request of the Board of Trustees of the AMA and against the best wishes of the Michigan delegation, the resolution was withdrawn. If that resolution were now on the books, the bargaining position of the whole medical profession would be greatly improved, because it would show foresight and forethought for our good name.

To be indicted is no proof of guilt, but such an action unavoidably carries a degree of taint with it, and places the burden on the defendant, of clearing a good name instead of making the accuser prove his case.

The medical profession has a duty to perform.

COMPULSORY WELFARE PLANS

LEST OUR MEMBERS be under the impression that our drive against the Welfare State (State Socialism) is temporarily in abeyance because of the defeat of the President's Reorganization Plan No. 1, the recess of the Congress, and the reported likelihood that some of the National Health Plan Bills now before the Congress will not be enacted, we are reporting on the progress of the compulsory program throughout the nation.

The growing interest in compulsory welfare plans this year is evidenced in sixteen state legislatures where seventy-one compulsory cash sickness bills were introduced. Last year there were forty-two similar bills. Sixty-nine of this year's bills were defeated. The New York bill became law and the Washington Bill passed both houses, but must also be subject to a referendum vote in November, 1950.

Four states now have compulsory cash sickness insurance: Rhode Island, California, New Jersey, and New York, with Washington to be decided. The Rhode Island plan is a state monopoly. In California there is a state fund, but private interests may compete, and about one-third of the workers are so covered. The New Jersey plan is more liberal, and just over one-half are privately covered. In New York, broad opportunities are offered for private insurance.

The seventy-one bills in the legislatures this year were two in Colorado, eight in Connecticut, one in Delaware, two each in Florida, Illinois, and Maryland, fourteen in Massachusetts, three in Minnesota, one each in Montana, Nevada, and New Mexico, twenty-one in New York, three in Pennsylvania, two in Tennessee, five in Washington, and three in Wisconsin. These all carried

weekly benefits from as low as $5.00 to as high as $36.00.

These are an entry into the compulsory health insurance field, and may be a portent of further activity on the state level until such time as the national program may became a reality.

PREVENTION OF BLINDNESS

THE HIGH INCIDENCE of blindness resulting from glaucoma should give all physicians reason to pause and consider since most of it is preventable. Reliable statistics show that 66,000 persons in this country (one-eighth of all the adult blind) are blind in one or both eyes as the result of glaucoma, and most authorities are in agreement that another 800,000 persons have the disease in its early stages without realizing it. Blindness in this last group can be prevented if the individual can be found, warned, and treated in time. The family physician most often has the opportunity to see the patients first and so can be an important factor in preventing loss of sight from glaucoma. This has been aptly demonstrated by a joint exhibit of the Detroit Society for the Prevention of Blindness and the Grand Rapids Association for the Blind and for Sight Conservation at the recent meeting of the Michigan State Medical Society in Grand Rapids.

The physician should become suspicious of glaucoma in his patient over forty years of age, if the history shows frequent changes of glasses without relief, headaches after movies, halos or rainbows around lights, and intermittent attacks of blurry vision. Every physical examination should include a test of visual acuity and an ophthalmoscopic examination of both eyes. The former will reveal subnormal acuity in some early cases of glaucoma, and the latter may reveal a glaucomatous cupping of the optic disc.

Every suspicious case should be referred for further study to an ophthalmologist, who can establish the diagnosis by more refined tests, and much blindness can thereby be prevented. The physicians of Michigan should co-operate with the Detroit Society for the Prevention of Blindness and the Grand Rapids Association in their work in attempting to save sight.

EDWIN L. COOPER

* * *

EDITOR'S NOTE: The Editor would like to add one additional thought to Dr. Cooper's editorial on glaucoma. The alert ophthalmologist can detect a potential glaucoma before there has been serious disc excavation or contraction of the field by watching the increased tension and other symptoms, and the progress of this glaucoma may be stopped by the use of miotics. Small doses of pilocarpin will do no harm. The possibility of avoiding a threatened glaucoma is abundantly worth the effort and intensely satisfying to the ophthalmologist.

THE MICHIGAN HEART ASSOCIATION

THE MICHIGAN Heart Association was formed by a committee appointed by the Council of the Michigan State Medical Society in the fall of 1948 and was duly incorporated under the laws of the State of Michigan on February 17, 1949. Its Articles of Incorporation state that it is formed for the following purpose: ". . . the acquisition, dissemination and application of knowledge concerning the normal heart and circulation and the causes, diagnosis, prevention and treatment of disorders of the circulation and diseases of the heart, blood vessels and lymph vessels . . ." The Michigan Heart Association, therefore, is engaged in a community service program of research and education for the greater benefit of the people of Michigan.

In order to fulfill these aims, the Michigan Heart Association has become affiliated with the American Heart Association whose program and purposes are in harmony with its own, and has become a member agency of the United Health and Welfare Fund of Michigan for the purpose of raising the funds necessary for the accomplishment of its aims.

Already much has been accomplished toward perfecting an organization that can serve the profession and the citizens of this State in making available the very latest developments in the diagnosis and treatment of cardiovascular disease. In the field of research, the Michigan Heart Association actively supports several research projects approved by its medical advisory committee, embracing studies in congenital heart disease, electrocardiography in the young, cardiac surgery, coronary thrombosis, congestive failure, cardiac roentgenology and industrial cardiology. In the field of education the principal contribution of the Michigan Heart Association to date is its financial support of the Michigan Rheumatic Fever Control

(Continued on Page 1554)

POSTGRADUATE CONTINUATION COURSES

Wayne University College of Medicine December 5, 1949—March 11, 1950

These courses are open to all qualified persons.

Veterans who are not Residents in a Detroit hospital and who have Certificates of Eligibility under the GI Bill, should make arrangements for tuition and books, as provided by the GI Bill, by presenting these Certificates of Eligibility to Mr. Arthur Johnson, Veteran's Administrator at Wayne University, 5001 Second.

If you do not possess a Certificate of Eligibility, please call Mr. Johnson at Temple 1-1450, Veterans Affairs, before going to his office, and he will inform you what papers it is necessary to bring with you. *This must be completed before you register.*

Registration for these courses can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine, *before December 3, 1949.*

Title of Course	*Place*	*Time*	*Fee*
	Anatomy		
Surgical Anatomy (Limited to 20 Senior Surgical Residents)	College of Medicine	Tuesday, 3-5	$35.00
	Pathology		
Beginning Hematology	College of Medicine	Tuesday, 1-5	$50.00
Neuropathology	College of Medicine	Friday, 1-5	$50.00
Pathology of Neoplasms	College of Medicine	Wednesday, 1-5	$50.00
Histopathology of Ear, Nose and Throat	College of Medicine	Friday, 4-6	$25.00
	Physiology and Pharmacology		
Blood	College of Medicine (Two Quarters)	Friday, 4-5:30	$30.00
	Physiological Chemistry		
P. Chemistry Seminar	College of Medicine	Thursday, 3:30-4:30	$15.00
Intermediary Metabolism	College of Medicine	Friday, 1-2	$15.00
	Dermatology		
Dermatology Seminar	Receiving Hospital	Wednesday, 10-11:30	$15.00
Seminar in Dermopathology	College of Medicine	Tuesday, 11-12	$15.00
Conf. on Venereal Diseases	Social Hygiene Clinic	Thursday, 1-2:30	$15.00
Superficial Mycoses	Receiving Hospital (4th fl. Mycology Lab.)	Thursday, 10:30-12	$30.00
	Internal Medicine		
Medical Seminar	Receiving Hospital	Thursday, 6:30-7:30	$15.00
Medical Conference	Receiving Hospital	Saturday, 10:30-12	$15.00
Gastroenterology	Receiving Hospital (Limit 10)	Saturday, 8-9	$15.00
Medical X-Ray Conf.	Receiving Hospital (Limit 10)	Tuesday, 11-12	$15.00
	Surgery		
Seminar in Surgery	College of Medicine (Limit 20)	Monday, 4-5	$15.00

	Comprehensive Unit Course		
Basic Ophthalmology	College of Medicine (Limit 10)	Full Time (9 Months)	$900.00

This class will not be presented until September of 1950, but applications are being accepted at the present time, and the new class will be selected in March of next year. Application blank will be sent upon request to the Postgraduate department at the College of Medicine, 1512 St. Antoine, Detroit 26.

Michigan Heart Association

Allocations for Research and Education

1. **UNIVERSITY OF MICHIGAN MEDICAL SCHOOL, DEPARTMENT OF PEDIATRICS**

   (Dr. J. L. Wilson, University Hospital, Ann Arbor)

   Grant of $4,100.00 for research in congenital heart disease.

   1. Further work in congenital cardiac disease, especially in oxygen saturation and blood gas analyses studies.
   2. Travel fellowship to visit other cardiac centers.

2. **HENRY FORD HOSPITAL, DEPARTMENT OF PEDIATRICS**

   (Dr. R. F. Ziegler, Henry Ford Hospital, Detroit)

   Grant of $3,000.00 for research in electrocardiography as applied to infants and children.

   For the past four and a half years, Henry Ford Hospital has been interested in a detailed study of the electrocardiograms of normal infants and children, with a determination of such data as would be applicable not only to normal individuals, but also to the understanding of such basic problems as ventricular enlargement and defects of intraventricular conduction. In the latter field, a growing clinical practice has provided abundant material for detailed electrocardiographic studies; in addition, however, certain experimental work is indispensable for further understanding of problems involved in the derivation of specific electrocardiographic patterns.

   Important work which needs to be done includes the production, in experimental animals, of right and left ventricular hypertrophy. From such animals, the following data could be derived:

   1. Correlation of precordial electrocardiograms with direct leads from the epicardial surface of the heart.
   2. Correlation of the above with intracardiac leads.
   3. The influence in right and left ventricular hypertrophy of bundle branch block, artificially produced.
   4. A correlation of electrographic and physiological data derived from the above, plus cardiac catheterization studies.

3. **HENRY FORD HOSPITAL, DEPARTMENT OF SURGERY**

   (Dr. Conrad Lam, Henry Ford Hospital, Detroit)

   Grant of $3,000.00 for research in cardiac surgery.

   1. Investigation of pulmonary blood flow after pneumonectomy or ligation of the pulmonary artery.
   2. Continuation of experiments to see if the aortic valves can be transplanted.
   3. Continuation of experiments to see if suture anastomoses of blood vessels grow. This is of particular importance in relation to operations for coarctation in infants or young children, as well as in the various shunt operations in tetralogy of Fallot.
   4. Continuation of study of closure of interatrial and interventricular defects.

4 **HENRY FORD HOSPITAL, DEPARTMENT OF MEDICINE**

   (Dr. Ben E. Goodrich, Henry Ford Hospital, Detroit)

   Grant of $3,000.00 for research in coronary thrombosis.

   Heparin is being used as a part of the anticoagulant therapy of patients threatened with, or suffering from, coronary artery thrombosis. It has been established that protamine, introduced into blood vessels, neutralizes the effect of heparin. At the present time, there is an extensive use of protamine zinc insulin in the treatment of diabetes. Is it possible that some portion of the protamine has an undesirable effect on the coagulation of blood of diabetics who are already predisposed to coronary artery disease by reason of their diabetes?

   It appears reasonable to attempt to discover the quantity of protamine and the quantitative effect of such protamine on the coagulability of blood in patients receiving the medication. The clinical study would relate to the effect on blood coagulability of various forms of insulin. The animal study to supplement the above would determine the ranges of effect in degrees that would not customarily be used clinically.

5. WAYNE UNIVERSITY SCHOOL OF MEDICINE, DEPARTMENT OF MEDICINE

(Dr. Gordon B. Myers, Receiving Hospital, Detroit)

Grant of $15,000.00 for research in diseases of blood vessels.

The first phase of the study will be concerned with the determination of potassium and sodium balance in cardiac decompensation and during recovery. The balance studies will be correlated with various cardiac function tests to evaluate their significance. Cardiac output will be determined with the aid of catheterization if equipment is obtained. Since digitalization in animals is accompanied by shifts of sodium into and potassium out of heart muscle cell, patients will be divided into two groups, depending upon whether cardiac glycosides are given, in order to gain further data on the influence of digitalis and allied drugs on blood and muscle potassium. The second phase of the study will be to determine the effect of potassium pushed to the limit of tolerance (as judged by blood level, electrocardiogram, and clinical manifestations) upon cardiac function in (a) the digitalized, and (b) the supplementary potassium to be of value in refractory congestive failure and it is hoped that these studies will provide quantitative data on the optimal intake of potassium and sodium in congestive failure.

6. HARPER HOSPITAL, DEPARTMENT OF LABORATORIES

(Dr. Kenneth Corrigan, Harper Hospital, Detroit)

Grant of $6,500.00 for the study of anomalies of the heart by means of x-ray examinations and cardiac catheterization.

1. Cardiac surgery on congenital heart patients and on experimental animals: A method has been devised whereby septal defects can be created in animals and the abnormal physiology studied. The defects can, at a later date, be repaired and the circulation restored to normal.
2. Development of new diagnostic techniques: There are, at the present time, certain research procedures which have been established in animals and which appear to have direct and valuable bearing upon clinical application in the study and evaluation of heart conditions preparatory to cardiac surgery. It is desired to perform more work on these procedures and bring them to direct clinical utilization.
3. Research and development program to study and further evaluate techniques now in existence, including the study of cardiac physiology and the measurement, localization and precise evaluation of cardiac defects: Certain of the procedures mentioned in paragraph one have been shown applicable to this work but further work is badly needed to evaluate the procedures now known and to develop new ones.

7. INDUSTRIAL CARDIOLOGY

(Dr. John G. Bielawski, Detroit)

Grant of $6,000.00.

This research project is concerned directly with the problems of heart disease in industry, both labor and management. It will establish proper methods of discovery of heart disease when first entering employment and methods of determining the working capacity of those afflicted and placement in jobs suitable to their capabilities.

8. RHEUMATIC FEVER CONTROL PROGRAM OF THE MICHIGAN STATE MEDICAL SOCIETY

Grant of $32,000.00.

The Rheumatic Fever Control Program is concerned with the detection of rheumatic fever and rheumatic heart disease. It is a state-wide program grouped around the important medical centers of the state where adequate facilities for diagnosis are available. The program is fundamentally educational.

A feature of the Rheumatic Fever Control Program is thirty Consultation and Diagnostic Centers scattered throughout the State, where difficult cases can be evaluated, diagnosed, and treatment recommended.

9. AMERICAN HEART ASSOCIATION

Grant of $32,000.00.

The Michigan Heart Association is an affiliate of the American Heart Association, a national organization concerned with the fight upon heart disease through research and education. One-half of this sum is specifically committed to research in diseases of the heart and blood vessels. The other half is used for the Association's national educational campaigns.

10. EDUCATIONAL PROJECTS

A sum of $10,000.00 has been set aside for the lay and professional education efforts of the Michigan Heart Association. This educational program will feature lay and factory education and publicity through speakers' bureaus, radio, exhibits for fairs and factories, pamphlets, etc. This is in the course of preparation.

MEMBERSHIP DUES

Annual (Voting) Membership plus subscription to "Modern Concepts of Cardiovascular Disease"..$ 5.00

Annual (Voting) Membership plus subscription to "Modern Concepts of Cardiovascular Disease" and "Circulation" (the official organ of the American Heart Association).....$14.50

NOTE: Membership in the Michigan Heart Association automatically includes membership in the American Heart Association.

ANNUAL HEART DAY

Saturday, March 11, 1950
Book-Cadillac Hotel—Crystal Ballroom
PAUL BARKER, M.D., *Chairman*

Morning Session—9:00 a.m.

Address of Welcome—
WARREN B. COOKSEY, M.D.
President, Michigan Heart Association

"Hypertension"—
IRVINE H. PAGE, M.D., Cleveland, Ohio

"Arteriosclerosis"—
LOUIS N. KATZ, M.D., Chicago, Illinois

"Rheumatic Fever"—
HUGH MCCULLOCH, M.D., Chicago, Illinois

Luncheon 12:00 Noon

Luncheon Address—PAUL BARKER, M.D.
Incoming President, Michigan Heart Association

Afternoon Session—1:30 p.m.

First Annual Meeting of members of the Michigan Heart Association
Election of Officers

MICHIGAN HEART ASSOCIATION—OFFICERS AND COMMITTEES

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Table of Contents

TABLE OF CONTENTS

MICHIGAN STATE MEDICAL SOCIETY

Eighty-fourth Annual Session

DIGEST OF PROCEEDINGS OF THE HOUSE OF DELEGATES

MONDAY MORNING SESSION

September 19, 1949

The first meeting of the Eighty-fourth Annual Session of the Michigan State Medical Society, House of Delegates, held at the Pantlind Hotel, Grand Rapids, Michigan, on September 19-20, 1949, convened at ten-fifteen o'clock, J. S. DeTar, M.D., Speaker of the House, presiding.

I. Record of Attendance

Office	*Officer*	*Meetings* 1st	2nd	3rd	4th	5th
Speaker	J. S. DeTar	x	x	x	x	x
Vice Speaker	R. H. Baker	x	x	x	x	x
Secretary	L. Fernald Foster	x	x	x	x	x
Immediate Past President	P. L. Ledwidge	x	—	x	x	x
County	*Delegate*					
1. Allegan	L. F. Brown	x	x	—	x	x
2. Alpena-Alcona-Presque Isle	W. E. Nesbitt	Not Represented				
3. Barry	A. B. Gwinn	x	x	x	x	x
4. Bay-Arenac-Iosco	A. D. Allen	x	x	x	x	x
	W. S. Stinson	x	x	x	x	x
5. Berrien	D. W. Thorup	x	x	x	x	x
6. Branch	R. L. Wade	x	—	x	x	x
7. Calhoun	H. S. Hansen	x	x	x	—	x
	G. W. Slagle	x	x	x	—	x
8. Cass	S. L. Loupee	x	x	x	x	x
9. Chippewa-Mackinac	B. T. Montgomery	x	x	x	x	x
10. Clinton	G. E. Wahl	x	x	x	x	x
11. Delta-Schoolcraft	O. S. Hult	Not Represented				
12. Dickinson-Iron	D. R. Smith	x	x	x	x	x
13. Eaton	G. C. Stucky	x	x	x	x	x
14. Genesee	F. W. Baske	x	x	x	x	x
	C. W. Colwell	x	x	x	x	x
	J. E. Livesay	x	x	x	x	x
	C. K. Stroup	x	x	x	x	x
15. Gogebic	H. A. Pinkerton	Not Represented				
16. Grand Traverse-Leelanau-Benzie	D. G. Pike	x	x	x	x	x
17. Gratiot-Isabella-Clare	M. G. Becker	x	x	x	x	x
18. Hillsdale	L. W. Day	x	x	x	x	x
19. Houghton-Baraga-Keeweenaw	T. P. Wickliffe	x	x	x	x	x
20. Huron	C. W. Oakes	x	x	x	x	x
21. Ingham	R. S. Breakey	x	x	x	x	x
	L. G. Christian	x	x	x	x	x
	H. W. Wiley	x	x	x	x	x
22. Ionia-Montcalm	W. L. Bird	x	x	x	x	x
23. Jackson	C. S. Clarke	x	—	x	x	x
	J. D. Van Schoick	x	—	x	x	x
24. Kalamazoo	R. J. Armstrong	x	x	x	x	x
	W. A. Scott	x	x	x	x	x
	R. W. Shook	x	x	x	x	x
25. Kent	L. C. Carpenter	x	x	x	x	x
	G. W. DeBoer	x	x	x	x	x
	W. B. Mitchell	x	x	x	—	x
	S. L. Moleski	x	x	x	x	x
	Andrew Van Solkema	x	x	x	x	x
	A. V. Wenger	x	x	x	x	x
26. Lapeer	D. J. O'Brien	x	x	x	—	x
27. Lenawee	R. E. Dustin	x	x	x	x	x
28. Livingston	H. C. Hill	x	x	x	x	x
29. Luce	F. R. Koss	Not Represented				
30. Macomb	D. B. Wiley	x	x	x	x	x
31. Manistee	E. B. Miller	x	x	x	x	x
32. Marquette-Alger	N. J. McCann	x	x	x	x	x
33. Mason	E. B. Boldyreff	x	x	x	x	x
34. Mecosta-Osceola-Lake	T. P. Treynor	x	x	x	x	x
35. Menominee	J. R. Heidenreich	x	x	x	x	x
36. Midland	R. S. Ballmer	—	—	x	x	x
37. Monroe	T. A. McDonald	x	x	x	—	—
38. Muskegon	T. J. Kane	x	x	x	x	x
	R. D. Risk	x	x	x	x	x
39. Newaygo	B. L. Masters	x	x	x	x	x
40. North Central Counties	C. G. Clippert	x	x	x	—	x
41. Northern Michigan	J. R. Rodger	x	x	x	x	x
42. Oakland	H. A. Furlong	x	—	x	x	x
	C. R. Gatley	x	x	x	—	x
	J. M. Markley	x	x	x	x	x
43. Oceana	W. H. Heard	Not Represented				
44. Ontonagon	W. F. Strong	x	x	x	—	x
45. Ottawa	D. C. Bloemendaal	x	x	x	x	x
46. Saginaw	H. O. Helmkamp	x	x	x	x	x
	H. M. Bishop	—	—	—	—	x
47. Sanilac	R. K. Hart	x	—	x	x	—
48. Shiawassee	C. L. Weston	x	x	x	x	x
49. St. Clair	W. H. Boughner	x	x	x	x	x
50. St. Joseph	R. A. Springer	x	x	x	x	x
51. Tuscola	L. L. Savage	x	x	x	x	x
52. Van Buren	W. R. Young	x	x	x	x	x
53. Washtenaw	P. S. Barker	x	x	x	x	x
	O. K. Engelke	x	x	x	x	—
	B. M. Harris	x	x	x	x	—
	H. H. Riecker	x	x	x	x	—
	R. W. Teed	x	x	x	x	x
54. Wayne	W. W. Babcock	x	x	—	x	x
	L. J. Bailey	x	x	x	x	x
	C. J. Barone	x	x	x	x	x
	W. D. Barrett	x	x	x	x	x
	D. C. Beaver	x	x	x	x	x
	E. G. Bovill	x	x	x	x	x
	W. L. Brosius	x	x	x	x	x
	C. L. Candler	x	x	x	x	x
	J. E. Croushore	x	x	x	x	x
	M. A. Darling	x	x	x	x	x
	H. F. Dibble	x	x	x	x	x
	Douglas Donald	x	x	x	x	—
	L. S. Fallis	x	x	x	x	—
	H. B. Fenech	x	x	x	x	x
	E. H. Fenton	x	x	—	x	x
	R. F. Fenton	x	x	x	x	x
	C. K. Hasley	x	x	x	x	x
	L. T. Henderson	x	x	x	x	x
	L. W. Hull	x	x	x	x	x
	R. A. Johnson	x	x	x	x	x
	J. A. Kasper	x	x	x	x	—
	D. H. Kaump	x	x	x	x	—
	E. D. King	x	x	x	x	x
	E. G. Krieg	x	x	x	x	x
	H. J. Kullman	x	—	x	x	x
	E. H. Lauppe	x	x	x	x	x
	J. J. Lightbody	x	x	x	x	x
	J. E. Lofstrom	x	x	x	x	x
	G. T. McKean	x	x	x	x	x
	L. J. Morand	x	—	x	x	x
	H. L. Morris	x	x	x	x	—
	R. L. Novy	x	x	x	x	x
	G. C. Penberthy	x	x	x	x	x
	R. H. Pino	x	x	x	x	—
	W. S. Reveno	x	x	x	x	x
	E. D. Spalding	x	x	x	x	x
	E. C. Texter	x	x	x	x	x
	R. V. Walker	x	x	x	x	x
	Arch Walls	x	x	x	x	x
	F. A. Weiser	x	x	x	x	x
	Joseph A. Witter	x	x	—	—	x
55. Wexford-Missaukee	M. R. Murphy	x	—	x	x	x

THE SPEAKER: Gentlemen, since last we met the House of Delegates of the Michigan State Medical Society suffered the loss of several of its most honored members. These are: Dr. Stanley W. Insley, Wayne; Dr. Bruce H. Douglas, Wayne; Dr. Thomas K. Gruber, Wayne, a delegate to the American Medical Association; Dr. T. E. DeGurse, Councilor of the 7th District; Dr. T. Y. Ho, Clinton; Dr. George Waters, St. Clair; and Dr. E. R. Witwer, Wayne.

Shall we rise and observe a moment of silence in memory of these seven men?

P. E. SUTTON, M.D. (Oakland): Mr. Speaker, I move that we instruct the Secretary to write an expression of great loss and sympathy from this House of Delegates, and that that testimonial be spread on the minutes of this meeting and a copy be sent to the widows or survivors of these men, Dr. Insley, Dr. Douglas, Dr. Gruber, Dr. Ho, Dr. Waters, Dr. DeGurse and Dr. Witwer.

(The motion was severally seconded, was put to a vote, and was carried.)

VICE CHAIRMAN BAKER: Members of the House, it is now my pleasure to introduce to you the Speaker of the House, Dr. J. S. DeTar, who will give his Speaker's Address. Dr. DeTar. (Applause)

II. Speaker's Address

By J. S. DeTar, M.D., Milan, Michigan

In the National and State Educational Campaigns to educate the American people on current medico-socio-economic problems, much attention has been given to the rapid growth of *voluntary sickness and hospital insurance plans,* to the *success of the present free enterprise system* as reflected in longevity, low mortality rates, modern control of contagion, and other factors indicating that we have in America the *highest quality of medical care in the world today.* And much space has been devoted to indictments of the proposed government medical care system on the grounds of political infiltration, high cost, low quality of sickness care, bureaucratic control, and the fact that federal medicine represents a long step toward complete Socialism.

With the recent publishing of the Hoover Commission Reports, however, we have been given the materials for a different method of attack which to my mind has not been sufficiently exploited. And because the members of the House of Delegates are called upon throughout the State to *lead* in the current struggle to keep American medicine free, I am going to ask your indulgence for a few minutes for consideration of just two points, one concerning the Senate Bill (No. 1679), which would provide government medical care, and the other concerning the Hoover Report, which throws much light on the subject. I strongly believe that we, the delegates, have a personal responsibility to the members of the profession and to the public to provide logical analysis and interpretation in these matters.

The recommendations of the Hoover Commission have been highly respected in Congress. When the President tried to include education and medical care in a Department of Welfare *contrary* to the Commission recommendations, the Senate threw out his reorganization plan. Then, in contrast, when the President sent six more reorganization plans to the Senate *in conformity* with the Commission recommendations, all six were ratified in a single day.

Therefore, in any consideration of the problem of whether sickness care shall or shall not be assumed by the Federal Government, the findings and the advice of this Commission in its soul-searching analysis of the ills in the administration of our National Government, must be given a high priority.

The two points which I believe should be emphasized during the next few months are these:

1. That the President's plan for sickness care, Bill S. 1679,[1] does, *openly and definitely,* establish *Federal control* of all sickness care; and, call it what you will, that it is, strictly—Government Medicine, Federal Medicine, Socialized Medicine, despite all claims to the contrary.

2. That the Hoover Commission Report[9] provides overwhelming proof that the Federal Government is manifestly *unqualified* to assume the responsibility of sickness care on behalf of the people.

Simple, isn't it? And yet, if these two points can be proved to the American people to their satisfaction, Government medical care will be tossed from the ring in the first round of the 1950 battle. I believe the two points merit a few minutes of our time.

You are familiar with S. 1679. It consists of 163 pages. Over a third of it is devoted to compulsory sickness insurance, more than sixty pages. Of these sixty pages, twenty-four are devoted to a description of *decentralization*—of the administration of the scheme: local area committees, local professional committees, state administration, et cetera.

However, careful reading of these pages provides conclusive evidence that *local and state control are not even contemplated*—that the claim of decentralization is simply a sham—a blind behind which the socializers are hiding to lure their game into better shooting position.

All through the twenty-four-page section on "decentralization," one finds sentences like this:

"In the event of its disapproval of any (State) plan, the Board shall notify the State of its disapproval."[5] Note that the bureau in Washington may disapprove. Or this: "If within sixty days . . . the State has not submitted an approvable plan, the Board shall undertake the administration (of the plan). . . ."[5] Note that the bureau may here bypass the Governor and the State. Of this: "The Board shall have and discharge all authority and duties. . . ."[6] And this: "The Board shall make all regulations,"[7] and "Personnel of the Board shall be appointed by the Administrator."[8]

Note here that the Board has all authority, makes all regulations, and may set up its own system of sickness care in any state regardless of the wishes of the people in that state. I ask you: is this decentralized administration, or is it strict Federal Government control?

Next we find an elaborate organization of advisors presumably to keep the system as clean as possible. Now note how this Advisory Council is formed: "There is hereby established a National Advisory Medical Policy Council . . . to consist of the Chairman of the Board . . . and sixteen members appointed by the Federal Security Administrator. . . ."

Note here, as throughout the entire scheme, that *there is no state representation.* This Advisory Council is appointed by the Administrator in Washington. It is the familiar pattern of government by bureau which became so familiar during the war.

There is of course provided a method for citizens to register complaints before tribunals to be set up locally. Such complaints—in writing—will be heard before these bodies within the framework of this national bureau according to rules laid down by the bureau and its Administrator in Washington.

The point is a vital one: We have approval or disapproval, we have authority to make regulations, we have tribunals to hear complaints, all controlled by a Federal Bureau. The pattern is becoming a familiar one—not only in the field of medical care but in the fields of agriculture, education, housing, and insurance. This is a system of strict, centralized, bureaucratic control with no true decentralization.

All through the bill we find these phrases: "in the discretion of the Administrator;"[8] "the Administrator shall determine the sums . . . for . . . the States;"[2] "the Administrator shall approve . . ."[3] "the Administrator shall prescribe such regulations."[4]

There is no uncertainty about this phraseology. This scheme allocates all power, all authority, and all decision, with all controls and with the whip-hand of fund allocation to back it up, to a Federal bureau in Washington—just as is the case with socialized medicine in England today.

This point, the growing power of centralized government, is the occasion for serious thought by Joe Doakes and his wife. They are beginning to wonder just how far Federal taxation can continue to grow and still leave them enough to live on. And they are beginning to see that this proposed centralized control, this extension of the power of the Federal Government over the lives of the people has a strange similarity to the system of socialism in England. So they naturally ask, "If this scheme is actually Federal Government sickness care, just what

kind of a job can we expect the Federal Government to do for us when and if it actually takes over?"

This brings us to Point 2—the findings of the Hoover Commission,[9] because therein we shall find the answer.

The Second Point—Gross Inefficiency: The Commission Report provides overwhelming evidence that the Federal Government is manifestly unqualified to assume the responsibility of sickness care on behalf of the people. The Report discloses excessive cost, gross inefficiency, shocking waste, amazing overlapping and duplication of services, not only in medical and hospital and insurance fields, but in all fields investigated. And bear in mind that these disclosures are not the imaginings of a group of reactionaries bent on self-benefit; they are the findings of twenty-four impartial task forces of 300 leading citizens serving their Government.

Federal Employes: The Report tells us that it takes four times as many people to run the Federal Government as it did twenty years ago, and it explains *why* it takes so many:[11]

> "Too many supervisors believe that action to reduce the number of persons in their units will result in their salaries being reduced, while increases . . . will lead to their salaries being increased. This makes supervisors believe they will be rewarded for inefficiency, and encourages 'empire building.' "[12]

And the sad fact is that there are over 1800 of such bureaus in Washington vying with each other for increasing portions of the taxpayer's paycheck.

Low Estimates—High Costs to the Taxpayer: The Congressional Record is filled with projects presented to Congress with low original estimates and high final costs. One project was estimated to cost $44 million, and actually cost $131.5 million. Another was estimated at $6.5 million, and finally cost a whopping $93.5 million.[17] Amazing, isn't it? And yet compulsory sickness insurance is of the same cloth. As in England, no one has been able to put a top figure on the probable cost, because no one knows.

The Government Record in Business—The Post Office: Compulsory sickness insurance would constitute big business—billions of dollars every year. How does the Government run its other big businesses? The Report tells us about the Post Office business in these words: "Obsolete, . . . over-centralized, . . . outmoded laws . . . freezes progress . . . stifles proper administration . . . takes months to find records[15] . . . losing money up to $500 million this year . . . 22,000 employes politically appointed in spite of laws to the contrary.[16]

> And there is *no* evidence to indicate that the same Federal Government would do any better job in the care of the sick. Let's check the record in this field, since that is exactly what Joe Doakes and his wife are wondering about.

Sickness Care and Hospitals: The story is much the same here. The investigators found and reported "forty-four Federal agencies conducting medical or health activities without central supervision, and with no clear understanding as to who should be treated."[18] They report:

> "The enormous and expanding Federal medical activities are devoid of any central plan."[18] They add: "The Government is moving into uncalculated obligations without an understanding of their ultimate costs."[18]

Pretty strong words, aren't they? In the hospital field, they found gross waste, and more waste planned for the future. They found that the Veterans' Administration was planning to build hospitals with more than 50,000 additional beds when 30 per cent to 40 per cent of their beds were vacant.[20] And the Veterans Administration is only one of fourteen Federal agencies building and operating hospitals. They found that dozens of Federal hospitals could be closed. They conclude that "Federal agencies . . . compete with each other,"[19] and that using existing community hospitals would be more economical.[21] They found that Federal hospitals cost from $20,000 to $51,000 compared with $16,000 for voluntary hospitals.[19]

They discovered that in one small area there were eleven major Federal hospitals with so many full time physicians that there were only nine patients per doctor, and still a single agency planned to spend $100 million in this very area for more hospitals in spite of a vacancy rate which would have permitted actual closing of several of the eleven institutions without reducing service.

Much More Evidence: Are you shocked? You should be. And yet there are volumes of similar evidence. And still this scheme would turn over our sickness care to this type of administration. The report says: "Confusion in the Government agencies bewilders the citizen in his contacts with the Government,"[10] with . . . "deficiencies in training, overlapping functions, excessive details;" it cites an example of how long it took one supervisor to discharge a completely incompetent stenographer—seventeen months.[13]

It cites a $30,000,000 error in the budget caused by carelessness.[14] It tells of two bureaus each spending $250,000 to conduct an irrigation survey, exactly duplicating the work and the cost, with the taxpayer footing the bill. There is a long report on Federal operation of the insurance business, and it can be summarized in one sentence. "It takes four times as many employes to handle Veterans' insurance policies as the Metropolitan Insurance Company employs for the same number of policies."[22]

One could go on and on. Waste and inefficiency are apparently inherent in Federal government. The Hoover Commission has ferreted out the defects, and has pointed the way to their cure, tempered with the warning that some defects are so serious that no solution can be foreseen at present. Despite the conscientious work of thousands of Government workers, one is forced to summarize the description of government operation in most fields examined by the Hoover Commission in just two words: gross inefficiency. I therefore repeat point number two:

> The Hoover Commission report provides overwhelming proof that the Federal Government is manifestly unqualified to assume the responsibility of sickness care on behalf of the people. The evidence is strong; it is incontrovertible. It is indisputable.

I have a firm conviction that if the American taxpayer can have clearly demonstrated to him these two points: (1) that the program of Mr. Truman and Mr. Ewing is actually Federal Government, Socialized medicine, and (2) the Federal Government is unfit to assume this responsibility of sickness care for the people, the result will be quick and it will be sure. The American people will have none of it. The speed with which this end is attained will depend on the physicians of America, of which we in this room represent a sizable segment.

References

1. Bill S. 1679, 81st Congress, First Session.
2. Ibid, page 94.
3. Ibid, page 97.
4. Ibid, page 101.
5. Ibid, page 134.
6. Ibid, page 136.
7. Ibid., page 138.
8. Ibid, page 139.
9. Hoover Commission Report on Organization of the Executive Branch of the Government. New York: McGraw-Hill Book Co., 1949.
10. Ibid, pages 21-24.
11. Ibid, page 109.
12. Ibid, page 110.
13. Ibid, page 127.
14. Ibid, page 191.
15. Ibid, page 221.
16. Ibid, page 225.
17. Ibid, page 266.

18. Ibid, page 339.
19. Ibid, page 340.
20. Ibid, page 341.
21. Ibid, page 342.
22. Ibid, page 364.
23. Ibid, page 366.

CHAIRMAN BAKER: The report of the Speaker was referred to the Reference Committee on Officers' Reports.

(President Sladek read his address.) (Applause)

III. The President's Address

By E. F. Sladek, M.D., Traverse City

You have just heard a most illuminating and stimulating address by our Speaker. It proves but one thing; we doctors are now in politics with all that we have.

The success of our CAP campaign is an example of what we can do. Just because we have postponed national legislative action on socialized medicine is no reason to assume that the danger is past. We must continue our efforts at an ever increasing tempo until the social reformers in Washington fully and finally realize that their cause is lost, and that the people of this country do not want socialized medicine and the socialized welfare state. Just one week ago an election was held in a congressional district in Pennsylvania. The sole issue between the two candidates was socialized medicine and the Truman welfare state. The doctors, dentists, pharmacists, and nurses actively entered the campaign and won a decisive victory. This shows what organized effort can do.

Consideration of the work of this past year suggests that our doctors have been giving a major part of their attention to distant problems in the political field. This was occasioned by the existing national emergency. It is evident that more and more emphasis must be placed on local community and state health legislation in addition to that at the national level. We must strengthen our grass-root politics by an all out effort to know our state legislative representatives. All legislative work cannot be done in Lansing.

Our specific fight against socialized medicine is not enough. We, as a medical profession, must broaden our horizon, join with other organizations in an effort to stymie the new political and social philosophies which are attempting to develop a welfare state of which socialized medicine is only one segment.

During this past year the ramifications of the activities of the Michigan State Medical Society have been like a spiderweb of energy. The Report of the Council very briefly summarizes these and yet it requires nineteen pages in your handbook. In addition, Chairman Otto Beck will give you a supplemental report covering the last three months of the year. These two reports prove that our Michigan doctors are giving some of their time toward building up their profession. To review these would be a duplication of effort and would only take up your time.

To me, it is gratifying to note that our doctors are becoming interested in civic organizations. It is one of our duties that we do so. The layman looks up to a doctor and it is probable that his opinion carries more weight in discussion groups. An outstanding example was the organization of the Michigan Heart Association, a major portion of the Board of Directors being doctors. I can assure you that these doctors contributed much in the immediate and future planning of activities, with much respect and appreciation by the lay members. By medical stimulation the Michigan Health Council was reorganized into an active body. The remarkable success of the Rural Health Conferences with the resulting good will and respect for the medical profession by the other groups involved was well worth the effort put forth by the Michigan State Medical Society. Medical interest, co-operation, and participation in all civic groups is an objective towards which we should aim. Public good can only come from well planned projects based on sound knowledge. Projects involving health must have medical advice and supervision. We must seek further opportunities to offer our services.

The Michigan State Medical Society was established with its main objective being the improvement of the health of the people of the State of Michigan. The best public relations we have is to practice good medicine. We must become familiar with the newest therapeutic and surgical techniques and keep up to date with our swiftly advancing science of medicine. This Annual Session, during the next three days, is an outstanding opportunity to do this. Michigan leads the country and the world in offering continuation postgraduate courses to its physicians.

Besides practicing good medicine we do give consideration to the social aspects of medical practice. Many of our patients cannot afford the costs of modern medical and hospital care. Michigan's voluntary prepayment surgical and hospital plans contribute much towards this problem but only partly solve it. They should be expanded in scope, both as to numbers of subscribers and medical coverage. Ideally each one of us should give consideration to a patient's ability to pay. If we do, we most certainly will increase public respect for our profession.

Our prepayment medical care plan is the only plan of medical service in which we have the responsibility of development. Any competitive plan of government or non-medical agencies will be developed without the voice of the medical profession. If medicine has no voice in the formation of these plans, most certainly it will have no voice in their administration nor in the benefits they allow. It is time that we get down to a basic understanding of the problem. Full co-operation, full and enthusiastic support, full participation—that is the only answer to the proposed Washington legislation. It is your individual responsibility.

There is one very recent Council activity on which I wish to comment: the appointment of a joint committee from both the Michigan State Medical Society and the State Board of Registration in Medicine to develop a modernization of the Medical Practice Act. This will constitute a long range study and involve a series of legislative proposals. These will be important and will need the energetic support of everyone of us. I know that eventually all of our problems relating to legalization of medical practice will be solved.

THE SPEAKER: The President's address was referred to the Reference Committee on Officers' Reports.

IV. The President-Elect's Address

By W. E. Barstow, M.D., St. Louis

Most of the problems to be considered today have been ably discussed by preceding speakers. But certain matters are worth emphasis, even at the expense of repeating that which has already been stated.

Overshadowing much of the Society's local program is the urgent need to continue the CAP program in an extended and intensified form during the coming year. There is sure to be a much harder fight during the next session of Congress than during the last, as the strategists of the present Administration attempt to salvage the major elements of their campaign promises of 1948. We must continue our letters, telegrams, and personal contacts to Washington in varied form, and see that our patients, and friends do the same. This fight against socialized medicine may require the continuing effort of many years, but it will require an intensified effort this coming year. But if we fail, we may be sure that not only socialized medicine, but the cornerstone of the "Welfare State" will be ours to live with. No effort can be too great to avoid exchanging our birthrights for such a mess of pottage. The answer is we must not fail. We shall not fail. We will win this fight.

A second long range program is the question of impractices. This problem has been much discussed, but will bear still more discussion. And much more action. It is the one factor which, more than any other, is promoting political medicine. Commercialization, refusing to make night calls, or otherwise subverting medical service of the people to selfish interests, cannot but create a public receptive to argument for state medicine.

One of the most important of the Society's needs is adequate housing for the executive offices. The tremendous increase in number of worthwhile projects undertaken by the Society in the last few years, and the resultant increase in personnel employed, has created a demand for vastly larger working and record space. At the present time it appears impossible to rent the required space in Lansing. The only solution, apparently, is to buy or build such housing. Last year the House of Delegates authorized the council to rent larger quarters. Every effort has been made to find such quarters, but to no avail. Many state societies have felt that part, or even all of their reserves, furnish them a greater return when invested in a home building than when banked at 1 per cent. That is my feeling also. I urge you to give serious consideration to such action during this session.

A second state project for your consideration is a broadening of the base of our public relation activities. Many local societies are actively courting newspaper co-operation by staging dinners for newspaper editors and news editors of the various radio stations, and organizing co-operating committees to solve current public relations problems. It is probable that such public relations spadework could profitably be extended to every County Society. The medical profession can no longer wait for news agencies to ferret out its policies and programs. We must aggressively compete with other agencies, including those of our national government, for the privilege of giving to the public the truth about medicine.

You will note that many of the projects suggested for your consideration have been of national import, and have concerned the general public. More and more, in the present day, the medical profession is being forced into a position which it does not seek and for which it is not properly qualified, namely, the responsibility of explaning medical necessities to the American public. We are being placed in this position because false and untruthful explanations of the present situation and methods of health care are being made by those who would change the basic principles of medical practice. So we must give the people the *truth*. We have a notable advantage in this effort if we wish to make use of it. That advantage is, that while we may differ in small details we do present a united front on every major issue—a united front based on truths that have become known to us from long years of experience. It is these truths which if made self evident to the people will keep us and our patients—the people of Michigan—free.

THE SPEAKER: The address of the President-elect was referred to the Reference Committee on Officers' Reports.

V. Annual Reports of the Council

L. FERNALD FOSTER, M.D., secretary, presented a résumé of the Annual Report of The Council as printed in the Delegates Handbook.

O. O. Beck, M.D., Chairman of The Council, read the supplemental report of The Council.

SUPPLEMENTAL REPORT OF THE COUNCIL

1. *Membership*—As of September 10, 1949, the membership of the Michigan State Medical Society totalled 4,854 including 284 Military and Special Members who are relieved from paying dues and assessments.

2. *Finances*—The Constitution of the Michigan State Medical Society charges The Council with administration of the funds of the Society, and the Treasurer with responsibility for safekeeping of the Society's invested funds.

Following the mandate of the Constitution, The Council has caused an "annual audit to be made of the funds of the Society by a certified public accountant." The complete report of Ernst & Ernst, for the year 1948, was published in the March, 1949, issue of THE JOURNAL of the Michigan State Medical Society, beginning at Page 380. On Page 379 of the same number of THE JOURNAL is a copy of the MSMS budgets for the year 1949. The audit of Ernst & Ernst is and always has been open for inspection by any member of the Michigan State Medical Society who may call at the Executive Offices, 2020 Olds Tower, Lansing 8.

The report of our auditor for the first eight months of this year (that is, to September 1, 1949) of income and expense is as follows:

ACCOUNT:	On Hand 1-1-49	Income to 9-1-49	Expenses to 9-1-49	Balance on Hand 9-1-49
General Fund	$ 71,963.49	$ 52,930.78	$ 52,835.98	$ 72,058.29
Annual Session	—0—	20,225.00	4,822.78	15,402.22
Postgraduate Institute	—0—	8,380.00	9,678.13	1,298.13 Loss
The Journal	—0—	41,465.48	34,995.95	6,469.53
Public Education	—0—	113,318.75	61,200.39	52,118.36
Public Ed. Reserve	100,000.00	—0—	51,465.59	48,534.41
Rheumatic Fever	10,084.28	32,515.72	14,393.45	28,206.55
TOTALS	$182,047.77	$268,835.73	$229,392.27	$221,491.23

Estimated Over-all Budget for 1950

Estimated Income:		
1950 Dues (4,300 members at $37.00)		$159,100.00
(Allocated $10.50 to General Fund)	45,150.00	
(Allocated $1.50 to The Journal)	6,450.00	
(Allocated $25.00 to Public Education)	107,500.00	
Advertising Sales, Reprints & Cuts		57,600.00
Annual Session		13,280.00
Postgraduate Clinical Institute		8,000.00
Rheumatic Fever Program		15,000.00
Interest and Miscellaneous Income		800.00
TOTAL INCOME		$253,780.00
Estimated Expenses:		
Administrative and General Expense		$ 34,480.00
Society Expense		23,000.00
Committee Expense		13,500.00
Public Education Expense		72,800.00
Journal Expense		55,750.00
Annual Session Expense		13,280.00
Postgraduate Clinical Institute Expense		8,000.00
Rheumatic Fever Expense		28,900.00
Contingencies		4,070.00
TOTAL EXPENSES		$253,780.00

More detailed financial reports showing "Income and Accounts Receivable" and "Expenses" from January 1, 1949 to September 1, 1949, and also on the "Bond Account" as reported by the Treasurer to The Council at its meeting of July 9, 1949, have been presented today (in mimeographed form) to all members of the House of Delegates.

3. *Public Education Account*—This fund, accumulated from the special $25 assessment levied by the 1948 MSMS House of Delegates, has been used exclusively for public relations and public education purposes, as indicated in the following accounting for the first eight months of 1949:

PUBLIC EDUCATION ACCOUNT

Income:		
Assessment of Members		$113,068.75
Assessment of Members Prior Years		250.00
Total Income		$113,318.75
Expenses:		
Clipping Service	$ 170.29	
Committee Meeting Expense	435.66	
Equipment & Repairs	314.91	
Postage	918.46	
Printing, Stationery & Supplies	1,066.76	
Office, Rent and Light	347.04	
Salaries	11,387.07	
Telephone & Telegraph	1,574.52	

Travel Expense	1,437.49
Miscellaneous General Expense	877.46
Cinema	15,101.41
Newspaper Advertising	7,493.10
Publications & Pamphlets	336.69
Radio—"Tell Me, Doctor" programs	16,453.22
Schools—Sex Education and Libraries	2.50
Annual County Secretaries and Public Relations Conference	2,748.85
Second Rural Health Conference	521.71
Third Rural Health Conference	13.25
Total Expenses	$ 61,200.39
Balance on Hand September 1, 1949	$ 52,118.36

Public Education Reserve Account—Last January, the reserve for contingencies ($100,000) was placed at the disposal of the Special Committee on Education (composed of L. W. Hull, M.D., Detroit, Chairman, O. O. Beck, M.D., Birmingham, L. Fernald Foster, M.D., Bay City, C. E. Umphrey, M.D., Detroit) as The Council realized the imminent threat of political medicine—the emergency for which we had been building a reserve fund—had arisen. The Special Committee on Education reports the following expenditures in the Michigan CAP campaign which has successfully organized and unified the medical profession of this state in its open war against statism and collectivism—best exemplified by the successful fight last month against President Truman's proposed Reorganization Plan No. 1; the avalanche of concentrated activity on the part of our Michigan doctors more than justified the labor and expense of setting up the CAP program.

PUBLIC EDUCATION RESERVE ACCOUNT

On Hand January 1, 1949		$100,000.00
Expenses:		
Salaries	$ 22,928.45	
Printing, Stationery & Supplies	9,119.02	
Postage	420.26	
Telephone & Telegraph	706.93	
Travel	8,376.30	
Office Equipment	218.02	
Publications & Pamphlets	7,452.91	
Meeting Expenses:		
Special Committee on Education	451.98	
Field Secretaries	805.82	
Other Meetings	947.55	
Program (Radio, Cinema, Newspapers)	25.00	
Miscellaneous Expense	13.35	
Total Expenses		51,465.59
Balance on Hand September 1, 1949		$ 48,534.41

4. *Estimated Public Relations Expenditures Budget for 1950:*

Estimated Expenditures:	
Clipping Service	$ 300.00
Committee Meeting Expense	1,200.00
Equipment & Repairs	200.00
Postage	1,000.00
Printing, Stationery & Supplies	1,000.00
Office Rent and Light	1,800.00
Salaries	20,000.00
Telephone & Telegraph	1,200.00
Travel Expense	2,200.00
Cinema	5,000.00
Display Advertising	200.00
Newspaper Advertising	2,500.00
Publications & Pamphlets	5,000.00
Radio—"Tell Me, Doctor" Programs	19,000.00
Schools—Sex Education and Libraries	200.00
National Meeting Expense	500.00
Annual County Secretaries and Public Relations Conference	3,000.00
Miscellaneous General Expense	1,000.00
Michigan Health Council	7,500.00
Total Expenses	$ 72,800.00

Estimated Public Relations Reserve Expenditures Budget for 1950:

Estimated Expenditures:	
Salaries	$ 25,480.00
Printing, Stationery & Supplies	1,000.00
Postage	1,000.00
Telephone & Telegraph	1,000.00
Travel	10,000.00
Office Equipment	100.00
Publications & Pamphlets	5,000.00
Meeting Expenses:	
Special Committee on Education	500.00
County Society and other meetings	1,000.00
Other Activities	1,000.00
Total Expenses	$ 46,080.00

NOTE:

Out of the $213,318.75 available this year, approximately $145,000 will have been spent by December 31, 1949. The remaining $68,318.75, combined with an expected $107,500.00 (this dependent upon another annual $25 assessment) would give an amount of $175,818.75 for 1950.

Totaling the expense for Public Relations of $72,800 and for the CAP program of $46,080 under the above budget for 1950, the proposed expenditures would reach $118,880 with $56,938.75 still in reserve on December 31, 1950.

5. *Medical Public Relations*—Public thinking comes from (1) a deed—good or bad; and (2) the interpretation of the deed. Our MSMS Public Relations program attempts day after day to show dramatically that medicine is doing good deeds and to give the proper and repeated interpretations of those deeds; i.e., that medicine is solving its problems and that it is utilizing all means to improve the distribution of quality medical care to the people. But no public relations program and no amount of money, no matter how vast, can offset or even mitigate the evil doing, either by commission or omission, of a few members of the medical profession.

The Council again urges that every county medical society appoint a County Mediation Committee to cooperate with the Michigan State Medical Society Mediation Committee in the prompt adjudication of breaches of medical professional relations that continually plague our best efforts in public relations. The Council made this same plea one year ago but only nineteen County Medical Societies have reported to us the appointment of Mediation Committees.

6. *Michigan Medical Service.* An up-to-date report on this corporation, including finances, will be presented to you at the meeting of Michigan Medical Service membership tomorrow, September 20, at 2:00 p.m. in this room. All MSMS Delegates are members of the Michigan Medical Service Corporation, and are expected to attend this important meeting.

7. *Printing of House of Delegates Proceedings.* The publication in JMSMS of every word spoken during MSMS House of Delegates Sessions has become a dangerous practice so far as medical public relations are concerned. On occasion, the personal expressions and private sentiments of individual delegates have become embarrassing boomerangs to the entire medical profession. Therefore The Council feels that better public relations would be served if a résumé—containing in complete form all resolutions, motions, and actions of the House of Delegates—is ordered printed, conforming with the practice of the American Medical Association and other major state medical societies. *A recommendation on this subject follows.*

8. *Dispensing of Eye Glasses.* Last July, the County Societies Committee of The Council discussed the possibility of a need for a change in the 1948 ruling of the MSMS House of Delegates respecting eye glasses and their dispensing which ruling conflicts with the AMA resolution on rebates (Section 6, AMA Code of Ethics). *A recommendation on this subject follows.*

9. *Committee to Study Health Plans.* The Council respectfully reports the appointment of a Special Committee to carry on co-operation and investigation with representatives of farm, industry, labor, and small business

groups concerning health plans. The personnel of this Committee, which has held three meetings recently, is P. L. Ledwidge, M.D., Detroit, Chairman, A. S. Brunk, M.D., Detroit, L. Fernald Foster, M.D., Bay City, with O. O. Beck, M.D., Birmingham, Ex Officio as Chairman of The Council.

This Committee presented the following statement to The Council on September 18, 1949; after full and complete study The Council approved the statement and recommendation, as follows:

Michigan Medical Service

"The medical profession is dedicated to service. It alone can offer a service contract for medical care. This it did through Michigan Medical Service in 1939 for a specified income group.

"It is the opinion of The Council that certain changes in the present Michigan Medical Service contracts are indicated—because

1. They are necessary to preserve the philosophy of a 'Service Plan.'
2. Changing economic conditions have altered income values.
3. More people should be provided complete coverage if Michigan Medical Service or the voluntary pre-payment system is to compete successfully with proposed compulsory plans of the Federal government and other plans in which organized medicine would have little or no voice.

"These changes have been indicated for some time by the economic and political factors inherent in our national life. If the philosophy upon which Michigan Medical Service was created in 1939 was sound then, it should be sound now. To keep it sound now the plan needs definite revisions so that it can continue to serve the same economic groups and provide a solution for the social and economic problems for which it was originally developed.

"THEREFORE—The Council recommends, that in keeping with this concept, The House of Delegates of the Michigan State Medical Society requests Michigan Medical Service to:

(a) Increase the income limits to $5,000.00.
(b) Increase the schedule of fees paid physicians.
(c) Provide that all hospital services of physicians, both Medical and Surgical, be included as benefits.
(d) Continue all the present forms of contracts affecting the $2,500.00 income limits."

This Recommendation is repeated among the other Recommendations of The Council, at the end of this report.

10. *More Space for Executive Offices.* Negotiations for the purchase of the small building in Lansing, described in the Annual Report of The Council (on Page 53 of Handbook for Delegates), are presently at a standstill. The Lansing Planning Commission was favorable to rezoning the property to permit its use by the Michigan State Medical Society, but the owner suddenly changed his mind on the price. If this building cannot be purchased within a reasonable time for the sum of money originally agreed upon, the Society will decide upon another site available to MSMS for a permanent home.

11. *Veterans Administration Hospital in Ann Arbor.* The newspapers recently carried a story that a Veterans Administration General Hospital in Ann Arbor would be built at a cost of over $7 million dollars. This is at variance with the wishes of the MSMS House of Delegates expressed in its resolution unanimously adopted on September 20, 1948, which stated in part: "That to establish a Veterans Administration General Hospital near Ann Arbor at this time is not necessary and not in the best interests of the public."

12. *AMA Assessment.* Michigan is seventh among the fifty-three constituent societies of the American Medical Association in payment of the AMA Assessment. Eighty-two per cent of our members have co-operated and given wholehearted support to our parent organization. To the other eighteen per cent, we hope that The Council's recommendation No. 1 (to be found on page 56 of the Handbook for Delegates) will be read and followed.

Recommendations

We respectfully invite to your attention the six recommendations in the original report of The Council printed in the Handbook on Pages 56-57. They read as follows:

The Council recommends:

1. That each and every member of the Michigan State Medical Society co-operate wholeheartedly and to the best of his ability, both by action and financially, to the National Education Campaign of the American Medical Association and that each member feel it an honor and a privilege to aid the AMA not only by payment of the small AMA assessment but by vigorously entering the AMA program of active and direct resistance against attempts to throw the practice of medicine into politics.
2. That the MSMS Legislative Committee be instructed to reintroduce into the 1951 Legislature a proposal similar to S.B. 292 of 1949, to permit the exemption of interns and residents from the provisions of licensing under the Michigan Medical Practice Act for a period of not over six years in order to authorize post-graduate hospital training beyond one year and to encourage more doctors of medicine to train and locate in this State; and that the Legislative Committee utilize all its efforts, well in advance of the 1951 Legislative Session, to insure that this proposal is well understood and is favorably received by the Michigan lawmakers and all other parties in interest.
3. That the House of Delegates specifically authorize The Council to purchase or build a building with suitable space and dignity, to house the Executive Offices of the MSMS, so that the critical situation of overcrowding in the present inadequate space is remedied.
4. That the Committee on Constitution and By-Laws of the House of Delegates be requested to give consideration to several necessary amendments to the 1948 revised Constitution and By-Laws, recently referred to The Committee by The Council.
5. That Wilfrid Haughey, M.D., of Battle Creek, longtime Councilor and former State Society Secretary, who is presently Editor of the Michigan State Medical Society Journal and official representative of the State Society to numerous ancillary health groups, be considered by the House of Delegates as recipient of an award, to be designated as "President for a Day"; this honor to be conferred on the occasion of Officers Night, September 21, 1949, during the Michigan State Medical Society Annual Session in Grand Rapids.
6. That the special assessment of $25, be continued for the year 1950, in order to meet the need of additional funds for various purposes in the work of the Michigan State Medical Society.

The Council respectfully submits three additional recommendations:

7. That the House of Delegates requests Michigan Medical Service to:
(a) Increase the income limits to $5,000.00.
(b) Increase the schedule of fees paid physicians.
(c) Provide that all hospital services of physicians, both medical and surgical, be included as benefits.
(d) Continue all the present forms of contracts affecting the $2,500 income limits.
8. That the House of Delegates instruct the Publication Committee of The Council to publish only a résumé of the annual Proceedings of the House of Delegates, which shall include in complete form all resolutions, motions and actions of the House.

9. That the House of Delegates give study to clarify the conflict between the American Medical Association interpretation and the 1948 MSMS House of Delegates resolution on the subject of dispensing of eye glasses.

Respectfully submitted,

O. O. Beck, M.D., *Chairman*
R. J. Hubbell, M.D., *Vice Chairman*
C. E. Umphrey, M.D.
P. A. Riley, M.D.
Wilfrid Haughey, M.D.
J. D. Miller, M.D.
R. C. Pochert, M.D.
H. B. Zemmer, M.D.
L. C. Harvie, M.D.
E. A. Oakes, M.D.
F. H. Drummond, M.D.
C. A. Paukstis, M.D.
A. H. Miller, M.D.
W. S. Jones, M.D.
D. W. Myers, M.D.
E. A. Osius, M.D.
William Bromme, M.D.
W. B. Harm, M.D.
J. S. DeTar, M.D.
E. F. Sladek, M.D., *President*
W. E. Barstow, M.D., *President-Elect*
L. Fernald Foster, M.D., *Secretary*
A. S. Brunk, M.D., *Treasurer*
P. L. Ledwidge, M.D., *Immediate Past President*

The Speaker: The supplemental report of The Council was referred to the Reference Committee on Reports of The Council, with the exception of all that part which dealt with Michigan Medical Service and the recommendations to Michigan Medical Service, which was referred to a combined committee, consisting of the Reference Committee on Reports of The Council and the Reference Committee on Medical Service and Prepayment Insurance. The Chairman of that Committee was designated as Dr. Palmer Sutton, who is Chairman of the former Committee.

VI. Report of Delegates to AMA

The report of the Delegates to the American Medical Association, given by L. G. Christian, M.D., of Lansing, Chairman.

This report covers the interim session held at St. Louis and the annual session at Atlantic City. The interim session report was made to The Council and will not be read here unless you request it. The Council already has had it and has digested it. If anyone wants to know what happened in St. Louis I will be glad to read it. The main thing that did occur at St. Louis was the Michigan and California resolutions setting up the $25 assessment for the American Medical Association, which put the American Medical Association in a position actually to combat the things that are going on in Washington.

The House of Delegates convened Monday, June 6. All Michigan delegates, including Dr. Ralph A. Johnson, alternate, were present at all meetings. Your delegates met on Sunday night previous, and also met with delegations of other states and sections. We had conferences with the President and representative members of the Board of Trustees to present Michigan's views on problems confronting the medical profession.

Following the roll call the Distinguished Service Award was given to Dr. Seale Harris of Birmingham, Alabama. We refer you to the June 18 issue of J.A.M.A. for biography. Addresses by the Speaker of the House and the President, outlining the policies of the American Medical Association, were well received.

The report of the Board of Trustees is too long and complicated to be analyzed here. For those who care to read it you may find it in full in the J.A.M.A. for June 18, 1949. In passing, however, we might say it covers the following:

1. The report of the Secretary, financial statement, report of Medical Economic Research under direction of Dr. Frank Dickinson. This may be of interest to some of you, as it deals with life insurance examination fees.
2. Report on the Red Cross Blood Bank program.
3. Report of the Committee on Rural Health.
4. Recommendations regarding the Advisory Board for Medical Specialties.
5. Treasurer's report.
6. Auditor's report.
7. Report of the Committee on Hospitals and the Practice of Medicine. Your delegates would strongly urge every practicing physician to read this report. Study it and discuss it at staff meetings, as it is of vital interest to every practitioner of medicine who cares for patients in hospitals. It is exhaustive and authoritative.
8. Code of Ethics of World Medical Association.
9. Report of the Council on Industrial Health.
10. The American Medical Association program. Since you all know it, we will not discuss it here.
11. Mental hygiene.
12. Veteran medical care.
13. Industrial medicine.
14. Medical education and personnel; adequate funds free of political control. They suggest that various funds be given to our universities to keep them free from political control.
15. Activities of the Editor. Dr. Henderson presented the following report, which was referred to the Reference Committee on Reports of Board of Trustees and Secretary:

"The Board of Trustees is aware of the criticism of the Editor coming from within and from without the profession. The Board recognizes that the public has come to believe that the Editor is spokesman of the Association. The membership undoubtedly wishes the elected officials to speak authoritatively on all matters of medical policy.

"Against the time when the Editor retires, Dr. Austin Smith has for some months been in training as the Assistant Editor, and the talent of the Editor will be retained for the present under the control of the Board of Trustees.

"In view of the increasing responsibility of the Editor and reorganization of the department, the Board of Trustees has decided on the following points:

"1. The Editor will completely eliminate speaking on all controversial subjects, both by platform and by radio. Approval of all speaking engagements will be made by the Executive Committee.

"2. Elimination of all interviews, including press conferences, and statements by Dr. Fishbein except on scientific subjects.

"3. Editorials on controversial subjects will be supervised by the Executive Committee.

"4. Complete information as to these activities will be reported to the members of the House of Delegates.

"5. There will be permanent elimination of the Diary in Tonics and Sedatives.

"6. Plans for the training of a new Editor in an orderly manner, including the retirement of the present Editor, will be formulated.

"The Board of Trustees of the American Medical Association announces that plans have been formulated for the retirement of Dr. Morris Fishbein as Editor of the *Journal of the American Medical Association* at an appropriate time. For thirty-seven years Dr. Fishbein has served the American Medical Association well and faithfully. The *Journal of the American Medical Association* is an enduring monument to his genius and devotion. His activities have extended far beyond his immediate duties as an Editor, and the Board desires to pay tribute to his many accomplishments in other fields.

"The Board finds that serious dislocation would result from any sudden replacement. With this in mind, a reorganization of the editorial staff is under way so that his retirement, when consummated, will not result unfavorably for ventures of the Association.

"Respectfully submitted,

Elmer L. Henderson, M.D., *Chairman*
Edwin S. Hamilton, M.D., *Secretary*
Louis H. Bauer, M.D.
John H. Fitzgibbon, M.D.
James R. Miller, M.D.
Walter B. Martin, M.D.
Dwight H. Murray, M.D.
Edward J. McCormick, M.D.
Gunnar Gundersen, M.D."

16. General Practice Sections on Hospital Staff. Resolution on the General Practitioner: Your Committee was much impressed with the arguments set forth by the proponents of this resolution, and is of the unanimous opinion that the general practitioner, who is in fact the very backbone of American medicine, should be assisted in every way possible to advance himself.

Your Committee is of the unanimous opinion that better training facilities should be arranged as promptly as may be found feasible, and that the American Medical Association should most urgently insist that hospitals make freely available to qualified general practitioners all of their facilities for the care of the sick.

Your Committee believes that it is the opinion of this House of Delegates that the reason for the existence of hospitals is for the better care of the sick, and for the promotion of the health of the American people. Your Committee believes that it is the opinion of this House that these ends will be best served by the existence of a large number of well-trained, thoroughly qualified general practitioners able to admit their patients to the hospitals in order that they may give them the very best medical care that may be provided.

To this end your Committee has rewritten the resolution introduced by Dr. DiNatale and submits it to the House of Delegates as a substitute resolution:

Whereas, for the best interests of his patient the general practitioner at this time deserves particular consideration; therefore, be it

"RESOLVED: That (1) graduate and postgraduate education for general practitioners should be made more widely available; and (2) two-year rotating internships especially designed for those who wish to train for general practice be set up as rapidly as possible."

Three of your delegates were appointed and served on Reference Committees—Dr. Barrett, Hyland, and Christian.

The Council on Medical Service made a long and exhaustive report on prepayment plans. We will now call on R. L. Novy, M.D., President of the Michigan Medical Service, who will speak on this subject. Dr. Novy was in conference with the Council and knows more inner workings than do we.

R. L. NOVY, M.D. (Wayne) presented a brief statement on the status of the American Medical Association in regard to prepayment medical care plans.

L. W. CHRISTIAN, M.D.: The following resolutions were presented:

A—Improvement of the education of the general practitioner. Approved.

B—The $25 assessment. Approved.

C—Condemned compulsory health insurance. Approved.

D—Voluntary health insurance. Approved.

E—Hospital and medical care of veterans for non-service-connected disabilities. Lost by a close vote. We feel it will be brought in again, as it appears to be of extreme importance to the veteran and the medical profession.

F—Asking AMA to be the sole agency to inspect hospitals. Disapproved because of the friendly relations with the College of Surgeons, and the added cost to the AMA. The Committee offered a substitute resolution, which is as follows:

"RESOLVED: That the American Medical Association highly commends the American College of Surgeons for its long-sustained efforts in the field of hospital standardization, and endorses its continued activity in this important field; and be it further

"RESOLVED: That the Secretary of the American Medical Association transmit a copy of this resolution to the Board of Regents of the American College of Surgeons." Approved.

G—Michigan resolution supporting AMA program and assessment. Approved, only after disapproval by reference committee.

H—Concerning study of intern training program. Approved.

I—Associated medical care plans enrollment agency. Approved.

Addresses of Leone Baxter and Clem Whittaker were well received. These addresses were a progress report of the AMA fight against the Truman administration plan for compulsory health insurance. Both Whittaker and Baxter expressed confidence that with the help of the various state societies and individual physicians this fight can and will be won.

A new Code of Ethics prepared by the Judicial Council was adopted. We presume they soon will be distributed to every member of the AMA.

Heard addresses by Dr. A. Lawrence Abel of Great Britain, relating to the sad state of British medicine and urging us to remain free from political control.

Address of Surgeon General Clifford Swanson, Navy.

Address of Surgeon General Raymond W. Bliss, Army.

Election:

President—Dr. Elmer L. Henderson, Louisville, Kentucky
Vice President—Dr. James Francis Norton, Jersey City, New Jersey
Secretary—Dr. George F. Lull, Chicago, Illinois
Treasurer—Dr. Josiah J. Moore, Chicago, Illinois
Board of Trustees: Re-election of Louis Bauer, New York

The 1952 meeting will be held in Chicago.

Gentlemen, this is the end of the report. May I tell the House this:

Your delegates at this time would like to pay tribute to the man whom we considered represented you most adequately—Tom Gruber. He never practiced medicine, but was more interested in the welfare of the patient and improvement of the medical profession than many of us. He was kind, friendly, and fearless. He knew everyone in the House and all the officers of the AMA, who liked him and respected his opinions and listened to his advice.

To us, who served with him, he was an inspiration. His timely advice and his judgment kept us from making costly mistakes on many occasions. We were awed at times by his knowledge of the intent of the House. His predictions were astonishingly accurate. He was a source of accurate information. He will be difficult to replace. We will miss him.

THE SPEAKER: The report was referred to Reference Committee on Officers' Reports.

VII. Report of the Commission on Health Care

R. L. PINO, M.D. (Wayne): The problems concerned with the Commission on Health Care at its inception to some degree have been absorbed into other channels. These included problems of irregular practice, the Basic Science status, and Medical Associates.

During the past year publicity relative to Medical Associates has been carried on to a large extent through the Public Relations department. As noted in their report elsewhere in the Handbook, there have been many requests for the Medical Associates brochures. Some 15,000 copies have been distributed in secondary schools and colleges, to vocational counselors, and on request to many individuals and groups.

By invitation, the Commission has been represented before high school, college and faculty groups, with a response and interest of marked significance. The interest of parents, teachers and students in vocational goals is marked, and the opportunities in the health fields, as represented through Medical Associates, are receiving much attention through the distribution of the brochure. The woman's auxiliaries have been effective in this distribution and should receive much credit.

It was agreed at the beginning of the year with the Public Relations department that too concerted an effort toward the development of courses in public and private schools of the various sections of Medical Associates should not take place during this year, but rather for general publicity to take place and reactions noted.

With this year's experience it has increasingly become apparent that there is not only much interest educationally, but there is evidence of the increasing need of carefully worked out programs between educators and educational institutions with the medical profession in

enhancing the distribution of medical care by the training of more young people in these fields.

The problem is a large one in medical education and distribution in America, and one, it would seem, which should be promulgated comprehensively through a department of education or of distribution, or both, of the American Medical Association.

In Michigan the educational aspect of Medical Associates is of much favorable interest and concern in the Department of Public Instruction, and that Department has been most co-operative. What step should be taken next in an organized way, in connection with our teaching institutions in co-operation with the Michigan State Medical Society, demands study. The Commission on Health Care has created no expenditures this year directly other than any the Committee on Public Relations has made while the effect of the brochure and other contacts have been under observation.

It would seem that the activities of the Commission on Health Care should now be turned back to The Council for re-evaluation and direction or disposal into whatever channels The Council may deem appropriate.

Through the studies and observations of your Commission on Health Care we believe we can state unequivocally that the broad base of the pyramid upon which health care in America should rest will not be as stable as it could be if an Executive Vice President of outstanding potentialities, together with a strong cabinet of specialists in the fields of economics, of science, of law, education, distribution and public relations, were provided to assist the officers and Trustees of the American Medical Association in their very great responsibilities, which burden without adequate assistance they have borne voluntarily through the years.

THE SPEAKER: This report was referred to the Reference Committe on Miscellaneous Business.

VIII. Resolutions and Motions and Petitions

VIII—a. SPECIAL ASSESSMENT ($25.00) FOR 1950

A. D. ALLEN, M.D. (Bay-Arenac-Iosco):

"Whereas, the need of additional funds for various purposes in the work of the Michigan State Medical Society is apparent; therefore, be it

"RESOLVED: That the special assessment of $25 be continued for the 1950 year of the Michigan State Medical Society."

This resolution was referred to the Reference Committee on Reports of The Council.

IX. Reports of Standing Committees

Reports as printed in The Handbook, were presented as follows:

IX—a. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

IX—b. CANCER CONTROL COMMITTEE

IX—c. PREVENTIVE MEDICINE COMMITTEE

IX—d. COMMITTEE ON RHEUMATIC FEVER CONTROL

IX—e. MATERNAL HEALTH COMMITTEE

IX—f. COMMITTEE ON VENEREAL DISEASE CONTROL

IX—g. COMMITTEE ON MENTAL HYGIENE

IX—h. CHILD WELFARE COMMITTEE

IX—i. COMMITTEE ON IODIZED SALT

IX—j. GERIATRICS COMMITTEE

IX—k. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE.

IX—l. PUBLIC RELATIONS COMMITTEE

IX—m. COMMITTEE ON PUBLIC RELATIONS PUBLICATIONS

IX—n. COMMITTEE ON NEWSPAPERS

IX—o. SUBCOMMITTEE ON RADIO

IX—p. SUBCOMMITTEE ON CINEMA

IX—q. ETHICS

IX—r. LEGISLATIVE

IX—s. SCIENTIFIC WORK

IX—t. INDUSTRIAL HEALTH

IX—u. TUBERCULOSIS CONTROL

The reports of all these Committees were referred to the Reference Committee on Standing Committees.

X. Reports of Special Committees

X—a. COMMITTEE ON STATE VETERANS' AFFAIRS

X—b. COMMITTEE ON STATE INTERPROFESSIONAL COMMITTEE

X—c. THE BEAUMONT MEMORIAL COMMITTEE

X—d. THE SCIENTIFIC RADIO COMMITTEE

X—e. ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

X—f. LIAISON COMMITTEE TO THE MEDICAL ASSISTANTS SOCIETY

X—g. ADVISORY COMMITTEE TO THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

X—h. COMMITTEE ON INCREASE OF MEDICAL STUDENTS GRADUATED FROM MICHIGAN MEDICAL SCHOOLS

X—i. COMMITTEE OF SIX TO STUDY BASIC SCIENCE ACT AND MEDICAL PRACTICE ACT

X—j. PERMANENT CONFERENCE COMMITTEE WITH MICHIGAN HOSPITAL ASSOCIATION AND MICHIGAN NURSING CENTER ASSOCIATION

X—k. MICHIGAN STATE MEDICAL SOCIETY LIAISON COMMITTEE WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

X—l. MICHIGAN STATE MEDICAL SOCIETY LIAISON COMMITTEE WITH MICHIGAN HOSPITAL ASSOCIATION

The reports of all these Special Committees were referred to the Reference Committee on Special Committees.

VIII—b. MOTION FOR SPECIAL MEETING OF HOUSE OF DELEGATES ON SEPT. 19, 1949

E. D. SPALDING, M.D. (Wayne): Mr. Speaker, I move that we have a special meeting of the House at 2 p.m. to consider what resolutions may be brought forward at that time, so that the Reference Committees may devote this afternoon to their consideration.

W. B. MITCHELL, M.D. (Kent): I second the motion.

(The motion was put to a vote and was carried.)

The meeting was recessed at twelve-thirty o'clock.

MONDAY AFTERNOON SESSION

September 19, 1949

The meeting reconvened at two-fifteen o'clock, J. S. DeTar, M.D., Speaker of the House, presiding.

XI. Amendments to Constitution and By-Laws

XI—a. CH. 5, SEC. 3-g—BY-LAWS. RE ASSOCIATE MEMBERSHIP

C. K. HASLEY, M.D. (Wayne) introduced the following resolution:

"Whereas, there are some active members who are desirous of retaining their membership in the Michigan State Medical Society while pursuing postgraduate work, and it is deemed advisable that such members be exempt from the payment of membership dues and shall be classified as associate members for the term of their postgraduate work; therefore, be it

"RESOLVED: That paragraph (g) be added to Chapter V, Section 3 of the By-laws, to read as follows:

"'(g) An active member, by transfer, for the period

of one year while he is temporarily out of practice on account of postgraduate medical studies. This may be renewed upon petition to The Council at its discretion.' "

This resolution was referred to the Reference Committee on Constitution and By-laws.

XI—b. CH. 8, SEC. 2—BY-LAWS RE VOTING POWER OF VICE SPEAKER

E. D. SPALDING, M.D., presented the following resolutions that have to do with corrections of the amendment to the By-laws simply for the purpose of clarification.

"Whereas, according to the Constitution, Article IX, Section 1, a Vice Speaker of the House of Delegates is one of the six officers of the Society, aside from the Councilors, and

"Whereas, according to the By-laws, Chapter 8, Section 2, 'Officers of this Society shall be ex officio members of the House of Delegates, and, with the exception of the Speaker of the House of Delegates, shall be without power to vote in the House of Delegates', and

"Whereas, such a Vice Speaker as well as the Speaker are both duly elected delegates representing their County Societies, in contradistinction to the other four officers, and as such obviously should not be disfranchised; therefore, be it

"RESOLVED: That the By-laws, Chapter 8, Section 2, be amended by the insertion of the words 'and Vice Speaker' immediately after the word 'Speaker' in this Section."

This Section will then read, if amended, as follows: "Officers of this State Society and members of The Council shall be ex officio members of the House of Delegates and, with the exception of the Speaker of the House of Delegates and the Vice Speaker, shall be without the power to vote in the House of Delegates."

This was referred to the Reference Committee on Constitution and By-laws.

XI—c. CH. 9, SEC. 12, BY-LAWS—RE COUNCILOR DISTRICTS IN WAYNE COUNTY

E. D. SPALDING, M.D. (Wayne): "Whereas, according to its authority in the By-laws, Chapter 8, Section 3, the 1948 House of Delegates subdivided the 1st and 16th Councilor Districts (constituting Wayne County) to create two additional Districts, the 17th and 18th respectively, but did not specifically designate the boundaries of such, and

"Whereas, the local conditions in Wayne County are different from those in other Councilor Districts, it being a large metropolitan area; therefore, it is desirable to have the four Councilors representing this area selected at large, and not one from each of four permanently defined districts. In this way the ablest men available in the whole area may be selected irrespective of their location in the County, and

"Whereas, it is advisable to have this special procedure definitely set forth in the By-laws to avoid any future ambiguity; therefore, be it

"RESOLVED: That the By-laws, Chapter 9, Section 12, be amended by adding to this Section the sentence, 'Wayne County shall constitute four Councilor Districts without permanent set boundaries within that County,' and that the '17th District—Wayne' and '18th District —Wayne' be added to the Councilor Districts listed in this Section."

This Section then will read: "The following County Societies shall constitute the Councilor Districts of the States: . . . Wayne County shall constitute four Councilor Districts without permanent set boundaries within that County."

This resolution was referred to the Reference Committee on Constitution and By-laws.

VIII—c. PROPOSED REORGANIZATION OF AMA

R. H. PINO, M.D. (Wayne): "Whereas, the continuing brilliant advances made in the knowledge of health sciences has led to increasing complexities in the problem of applying these benefits to humanity, and

"Whereas, there are those that would deny the democratic process in the form they propose to use in applying these advances, implying that the freedom that brought forth these benefits is now incapable of dispensing them, and

"Whereas, the American Medical Association, representing the more than 140,000 practicing physicians in this country, is the responsible agency from which the profession, the Congress, and the public obtain impartial and accurate counsel, and

"Whereas, such increase in the administrative complexity has placed an ever-mounting burden on the leadership of the American Medical Association as to be now nearly beyond the possibility of continuing effective performance, without provision for adequate technical assistance and advice in the many fields affected, and

"Whereas, without such adequate technical assistance to leadership there is imminent danger that all that medicine has to contribute to the democratic social system be lost by default, thereby carrying down with it in its fall the other institutions of free enterprise; therefore, be it

"RESOLVED: That the necessary assistance to the leadership in the American Medical Association be provided by action of the House of Delegates of the American Medical Association, creating an Executive Vice President (not necessarily a Doctor of Medicine), assisted by a group of highly trained technical advisers in such fields as economics, public relations, government, political economy, medical education, medical distribution, and others; and be it further

"RESOLVED: That the Michigan delegates to the American Medical Association be instructed by this House of Delegates of the Michigan State Medical Society to present this resolution to the House of Delegates of the American Medical Association; and be it further

"RESOLVED: That all necessary measures be taken to inform other state societies of the wide purposes and intent of this resolution, and that before the next interim meeting, so that favorable support to this resolution may be effected."

This resolution was referred to the Reference Committee on Resolutions.

VIII—d. UNIFORM POLICY IN POLIO CASES

R. J. ARMSTRONG, M.D. (Kalamazoo): "Whereas, some local chapters of the National Foundation for Infantile Paralysis pay only part of the cost of polio care, and

"Whereas, good public relations demand the uniform State policy either for full payment or for assistance with Michigan Crippled Children Commission funds; therefore, be it

"RESOLVED: That the Michigan State Medical Society House of Delegates request the Medical Advisory Committee to the National Foundation for Infantile Paralysis to promote the establishment of such uniform policy for financial assistance to polio cases."

This resolution was referred to the Reference Committee on Hygiene and Public Health.

VIII—e. TESTIMONIAL TO THE LATE T. K. GRUBER, M.D.

"Whereas, the House of Delegates of the Michigan State Medical Society in the death of Thomas K. Gruber has lost an efficient and successful worker for the best ideals of the medical profession, and

"Whereas, Dr. Gruber was one who made a tremen-

dous contribution at the County, State and national level, and

"Whereas, he represented this body as a delegate to the American Medical Association for more than eleven years, and

"Whereas, we are charged with the heavy duty of continuing the effort with now his courage and example instead of his always cheerful and charming presence, and

"Whereas, work for the improvement of the profession is too often thankless and barren of marks of accolades; therefore, be it

"RESOLVED: That we, the delegates of the 84th meeting of the House, adopt this resolution as a token of our esteem and approbation; and be it further

"RESOLVED: That this resolution be spread upon the minutes, and a suitably embossed copy be presented to his widow as an expression of our loss."

This resolution was referred to the Reference Committee on Miscellaneous Business.

VIII—f. RELATIONS BETWEEN MEDICAL STAFF AND HOSPITAL MANAGEMENT

R. F. FENTON, M.D. (Wayne): "Whereas, instances of the arbitrary use of power on the part of hospital management which results on the nullifying of the express will of the majority of the doctors of medicine that comprise the medical staff, and

"Whereas, this unfortunate abuse can lead to alarming and dangerous consequences, not the least of which is misunderstanding and ill will between members of the staff and management and other serious rifts; for it must be emphasized that both groups need each other, and in an atmosphere of co-operation and trust to achieve the beneficial results so important to the ill and afflicted; therefore, be it

"RESOLVED: That the House of Delegates request the Council of the Michigan State Medical Society to take such appropriate action as will promote harmonious relations between the medical staff and hospital management and foster the generally prevailing good relations that exist between these two bodies."

This resolution was referred to the Reference Committee on Legislation and Public Relations.

(The meeting recessed at two-thirty o'clock.)

MONDAY EVENING SESSION
September 19, 1949

The meeting reconvened at eight-twenty o'clock, J. S. DeTar, M.D., Speaker of the House, presiding.

VIII—g. FUTURE COVERS OF HANDBOOK FOR DELEGATES

O. K. ENGELKE, M.D. (Washtenaw): "Whereas, the Handbooks for delegates for this session were covered with a rather homely blue substance which deposited noxious material on the hands of all diligent delegates; be it hereby

"RESOLVED: That all future Handbooks be given dignity and prestige through the use of a combination of the proper shades of maize and blue, colors which will never fade."

THE SPEAKER: All in favor will please say "aye."

The resolution was adopted.

Gentlemen, before we proceed with the evening's business, there are two gentlemen here from Wisconsin, and I would like to introduce them.

Mr. Charles H. Crownhart is Secretary of the Wisconsin State Medical Society, and Mr. Roy T. Ragatz is his assistant.

XII. Remarks of Guest Speaker Crownhart Re Medical Society Homes

MR. CHARLES CROWNHART: Mr. Speaker, and members of the House of Delegates of the Michigan State Medical Society: I would like very much indeed to make a soul-stirring address to you tonight on President Truman's false leadership, or on Oscar Ewing's misplaced ambitions, and in some respects I would like to come before you and say that in bringing you greetings from Wisconsin we are so accustomed to having Michigan first—Michigan first in one million enrolled, Michigan first in its football team, and things of that similar character. But I have been assigned tonight, and I am here by invitation on that assignment, to tell you the action that has been taken by the State Medical Society of Wisconsin in housing its executive staff in permanent headquarters.

I recall (not so many years ago, at that) that my father said he hoped I would have a long and successful career practicing law. I have been seduced into being a Secretary of a Medical Society.

In consoling me on my future practice in law, he said, "Charlie, I hope you will buy a home, incur the indebtedness early, pay it off during your career, because as you sink your roots deep and well into the Capital of your home State it will give assurance that you will remain there as an active practitioner in your profession."

I think it must have been something of that sort that influenced the Council of the State Medical Society, with the approval of our House, to authorize the purchase of a home in Madison, which is our State Capital, and where, of course, we feel the executive offices should be in their manifold connections with various State departments, not omitting by any means the fact that the State legislature meets there.

We have a three-story home on the shores of Lake Mendota, and I would like to give you all a very cordial invitation, any time you are driving through the southern portion of America's dairyland, to stop and pay that place a visit.

The executive activities of the entire Society are housed in that particular location. Not only is the Secretary's office there, but the executive activity in charge of the hometown care of the veterans' program is in that building, along with three employes of the Veterans Administration, and the executive staff of the prepaid insurance plans, modeled somewhat after Michigan's, known as Blue Shield in Wisconsin, who are also located in the Madison headquarters. We have a three-story building, one portion of which has been set aside so that committees and the Council may meet there as the occasion demands. We have a cateress who is employed to serve meals and appropriate sideline dishes on the occasion of those meetings.

Let me say that it has brought to the Medical Society in one short period of year a feeling of friendship and of fraternity that never existed before, even though that spirit did exist in large part. Physicians from out in the State including Milwaukee, stop to pay us a vist. They make the parlors their headquarters while there. There are magazines, there are plenty of opportunities to use the telephone, even to engage in dictation if they have a letter they want to get out. One section of the house is set aside for the use of the visiting—well, I hate to admit this, but the executive staff calls them the "visiting firemen." They are all very important, however, because they pay dues.

We have a dining room service that is utilized for the staff during noon hours, and the staff of some twenty-eight people group together in the dining quarters every noon except on Saturday. We have had meetings there not only with our own committees and our Council, but the public relations individuals in many activities in Madison also have met there. The State Board of Health, the State Board of Medical Examiners and, God forbid, the Woman's Auxiliary, all have joined to utilize the headquarters offices as an informal location for their periodic meetings.

We in Madison are blessed with the four beautiful lakes which Longfellow wrote about. All of that has brought to the staff an esprit de corps that has been

excellent; it has brought the Blue Shield and the Veterans Administration and the central office group a feeling that, after all, they are all working in the field of medical economics and in the service of the medical profession for the preservation of public health as we view it. The physicians themselves feel a solidarity and an interest that I am sure did not previously exist to the extent that it does today.

If Michigan were to emulate Wisconsin for the first time, it might be that Michigan would be wise to provide its staff and its officers and Councilors with similar facilities.

In a brief word let me say to you in all sincerity and in all interest that I think the last decade has brought to the profession of American medicine a feeling that state lines, as well as county lines and city lines and sectional lines, have disappeared—have been dissipated —in the common interest that is that of medicine in preserving to the American people the first example (and it will always be the example) of the American way of life—free medicine and high public health and standards in this country, any politician to the contrary.

THE SPEAKER: Mr. Crownhart and Mr. Ragatz, we want to thank you very much for coming here and telling us what you are doing in Wisconsin.

VIII—h. PETITION TO CREATE 19th COUNCILOR DISTRICT

F. W. BASKE, M.D. (Genesee): I have a petition and a resolution from Genesee County. They really go together, and I will read the petition first and then the resolution:

"To the House of Delegates, Michigan State Medical Society. Gentlemen: Genesee County has become one of the large component parts of the Michigan State Medical Society, and under the present organization there are times, covering a period of five or more years, when its Councilor does not live within the boundaries of the County, but in some other part of the District.

"Flint, being the second largest automobile manufacturing center in the world, has developed a situation where its problems of public relations with the laboring class is quite different than that of rural or less industrialized areas, and requiries close contact with our State officers at all times. A local Councilor who understands our mutual problems could best serve our interests and those of the State Medical Society in its effort to maintain the best of relations with the public.

"Therefore, the Genesee County Medical Society hereby petitions the House of Delegates of the Michigan State Medical Society to set aside the entire County of Genesee as the 19th District, with a Councilor of its own."

VIII—i. SURVEY OF MSMS COUNCILOR DISTRICTS

"Whereas, it is apparent from time to time that certain of the larger county medical societies are not represented on The Council nor in direct contact with the officers of the State Medical Society, and

"Whereas, we believe a more cohesive working unit could be secured by having every large county unit represented on The Council at all times, and

"Whereas, this cannot now be accomplished and still maintain adequate representation from the less populous areas; therefore, be it

"RESOLVED: That a special committee be appointed to study the possible regrouping of counties in Councilor Districts to attain better representation of the larger societies, and report their findings at next year's House of Delegates."

This resolution was referred to the Reference Committee on Constitution and By-laws.

XIII. Reports of Reference Committee

XIII—a. ON OFFICERS' REPORTS

W. S. REVENO, M.D. (Wayne): Your Reference Committee on Officers' Reports considered the addresses of the *Speaker of the House*, the *President of the Society*, the *President-elect*, and the report of the *delegates to the American Medical Association*, and have these comments to make:

1. Address of the *Speaker of the House*, Dr. John DeTar: Dr. DeTar is to be commended for his very able presentation calling attention of the delegates to the glaring discrepancies inherent in Senate Bill 1679, and the commendable criticisms as enumerated in the Hoover Report. The issue of centralization v. decentralization was effectively enunciated and the need for close study of the Hoover Report as potent ammunition in the continuing defense against federal medicine was sharply emphasized.

2. *President Sladek's address:* The President called our attention to the importance of impressing on the public that federal medicine is not good for the American people; that we must strengthen our grass roots politics, broaden our horizon and join with other groups against the threat of socialization. Attention was directed to the community activities in which doctors had participated or been the leaders during the past year. These are the Michigan Heart Association, the Michigan Health Conference, and the Rural Conference on Health. The need for appointing a joint committee from the Michigan State Medical Society and the State Board of Registration in Medicine for revamping the Medical Practice Act was discussed.

3. Address of *President-elect Barstow:* Dr. Barstow emphasized the importance of continuing the C.A.P. program, broadening the base of our public relations activities, and constantly improving our contacts in Washington.

The failure of some physicians to fulfill their obligations in serving the public was decried, and the recommendation was made that such infractions be dealt with promptly through grievance committees at the local county medical society level.

Dr. Barstow urged prompt action in providing more adequate quarters for the executive offices of the Society.

4. Report of *Delegates to the American Medical Association*: This report, covering the interim session in St. Louis and the annual session in Atlantic City, is most comprehensive, and the delegates deserve commendation for their devoted interest and telling activity in behalf of organized medicine and this Society. They deserve honorable mention for their outstanding efforts in promoting the passage of a Michigan-sponsored resolution.

Your Committee was impressed with the high calibre of the addresses of the Speaker, President and President-elect, and the report of the delegates to the American Medical Association. It feels that the interests of the Society are secure in the hands of such capable men.

Mr. Speaker, I move the adoption of this report.

I. E. LOPSTROM, M.D. (Wayne): I second the motion.

The motion was put to a vote and was carried.

XIII—b. REPORTS OF THE COUNCIL

P. E. SUTTON, M.D.: *This Reference Committee reviewed the annual report for 1949 of The Council and approved the entire report as contained in the Handbook, pages 39 to 57, with two exceptions, on which I will now comment.*

Exception 1 is contained on page 41. This has to do with the Journal, and under the report on the Journal the Committee additionally recommends to the Publication Committee that in the roster number the addresses of the members be given.

The second exception is on page 55 and has to do with the report on Medical Library Service. This report is approved, with the additional recommendation that the accessibility of the University of Michigan Library Service be publicized to the membership.

I move the adoption of this report.

E. G. KRIEG, M.D. (Wayne): I second the motion.

The motion was put to a vote and was carried.

P. E. SUTTON, M.D.:

Exclusive of the report and recommendation pertaining to Michigan Medical Service, the Committee approved the Supplemental Report of The Council and recommendations contained in the report read by the Chairman of The Council, Dr. Beck, this morning, with one exception which has to do with their recommendation No. 9, our recommendation No. 8. I will read the resolution so you will know what we are adding.

The resolution as recommended by The Council is as follows:

"That the House of Delegates give study to clarify the conflict between the American Medical Association interpretation and the 1948 Michigan State Medical Society House of Delegates resolution on the subject of

dispensing of eye glasses. The Reference Committee further recommends that the matter be referred to The Council for study and action."

I move the approval of the Supplemental Report of The Council, with the exception of the item on Michigan Medical Service and the dispensing of glasses.

C. L. WESTON, M.D. (Shiawassee): Second the motion.
The motion was put to a vote and was carried.

P. E. SUTTON, M.D.: The first recommendation of The Council has to do with the Michigan State Medical Society and the American Medical Association in detail, as follows:

"That each and every member of the Michigan State Medical Society co-operate wholeheartedly and to the best of his ability, both by action and financially, to the National Education Campaign of the American Medical Association, and that each member feels it an honor and a privilege to aid the American Medical Association not only by payment of the small AMA assessment but by vigorously entering the AMA program of active and direct resistance against attempts to throw the practice of medicine into politics."

I move the adoption of that recommendation, Mr. Speaker.

B. M. HARRIS, M.D. (Washtenaw): Second the motion.
The motion was put to a vote and was carried.

P. E. SUTTON, M.D.: The second recommendation has to do with a legislative bill introduced in 1949 and not passed, as follows:

"That the Michigan State Medical Society Legislative Committee be instructed to reintroduce into the 1951 legislature a proposal similar to S.B. 292 of 1949, to permit the exemption of interns and residents from the provisions of licensing under the Michigan Medical Practice Act for a period of not over six years in order to authorize postgraduate hospital training beyond one year, and to encourage more doctors of medicine to train and locate in this State; and further, that the Legislative Committee utilize all its efforts well in advance of the 1951 legislative session, to insure that this proposal is well understood and is favorably received by the Michigan lawmakers and all other interested parties."

I move the adoption of this recommendation, Mr. Speaker.
C. S. CLARKE, M.D. (Jackson): I second the motion.
The motion was put to a vote and was carried unanimously.

P. E. SUTTON, M.D.: The third recommendation has to do with our need for a building:

"That the House of Delegates specifically authorize The Council to purchase or build a building with suitable space and dignity to house the executive offices of the Michigan State Medical Society, in order to remedy the critical situation of overcrowding in the present inadequate space."

I move the adoption of this resolution.
R. A. SPRINGER, M.D. (St. Joseph): I second it.
The motion was put to a vote and was carried unanimously.

P. E. SUTTON, M.D.: The fourth recommendation is as follows: "That the Committee on Constitution and By-laws of the House of Delegates be requested to give consideration to several necessary amendments to the 1948 revised Constitution and By-laws recently referred to the Committee by The Council."

I move the adoption of this recommendation.

L. T. HENDERSON, M.D. (Wayne): Second the motion.
The motion was put to a vote and was carried unanimously.

P. E. SUTTON, M.D.: The fifth recommendation is as follows: "That Wilfrid Haughey, M.D., of Battle Creek, long-time Councilor and former State Society Secretary, who is presently Editor of the Michigan State Medical Society Journal and official representative of the State Society to numerous ancillary health groups, be considered by the House of Delegates as recipient of an award, to be designated as 'President for a Day'; this honor to be conferred on the occasion of Officers' Night, September 21, 1949, during the Michigan State Medical Society annual session in Grand Rapids."

I move the adoption of this recommendation.
The motion was severally seconded, was put to a vote, and was carried unanimously.

P. E. SUTTON, M.D.: The sixth recommendation has to do with our special assessment, as follows: "That the special assessment of $25 be continued for the year 1950 in order to meet the need of additional funds for various purposes in the work of the Michigan State Medical Society."

I move the adoption of the recommendation.

C. L. WESTON, M.D.: I second the motion.
The motion was put to a vote and was carried unanimously.

XIII—b.-1. RESOLUTION ON SPECIAL ASSESSMENT ($25.00) FOR 1950

P. E. SUTTON, M.D.: The following resolution was presented to the House of Delegates this morning by A. D. Allen, M.D.

"Whereas, the need of additional funds for various purposes in the work of the Michigan State Medical Society is apparent; therefore, be it

"RESOLVED: That a special assessment of $25 be continued for the 1950 year of the Michigan State Medical Society."

The Reference Committee felt that inasmuch as the resolution from The Council covered the matter, this resolution should not be adopted.
I so move.

L. W. HULL, M.D. (Wayne): I second the motion.
THE SPEAKER: It is the opinion of the Chair, gentlemen, that we have adopted a recommendation but we have not adopted a resolution covering the same ground. If you wish to implement further your action, you may well adopt the resolution. There will be no mistaking the question then.
The Chair will ask all who are in favor of adopting the resolution authorizing $25 special assessment, to vote "yes." The Chairman of the Reference Committee recommended non-approval. I am going to ask for a vote of all those who are in favor of adopting the resolution.
If there is no further discussion, all those in favor of adopting the resolution will say "aye"; opposed, "no." *The motion is passed. The resolution is adopted, implementing the recommendation.*

P. E. SUTTON, M.D.: **The next recommendation is that the House of Delegates instruct the Publication Committee of The Council to publish only a résumé of the annual proceedings of the House of Delegates, which shall include in complete form all resolutions, motions, and actions of the House.**

I move the adoption of this recommendation.
ARCH WALLS, M.D. (Wayne): I second the motion.
The motion was put to a vote and was carried unanimously.

XIII—b.-2. COUNCIL'S RECOMMENDATION RE DISPENSING OF EYE GLASSES

P. E. SUTTON, M.D.: The next recommendation has to do with the eyeglass problem.

"That the House of Delegates give study to clarify the conflict between the American Medical Association interpretation and the 1948 Michigan State Medical Society House of Delegates resolution on the subject of dispensing of eyeglasses, and further recommend that the matter be referred to The Council for study and action."
(See Page 1509)

I move the adoption of this recommendation.
DOUGLAS DONALD, M.D. (Wayne): I second the motion.
After discussion, the motion was put to a vote and was lost.
THE SPEAKER: What is the pleasure of the House in regard to this matter? The matter still stands on the floor. We have the recommendation before us for our disposition. What is the pleasure of the House?
R. W. TEED, M.D. (Washtenaw): I move the question be referred back to the Reference Committee for further study.
J. R. HEIDENREICH, M.D. (Menominee): I second the motion.
The motion was put to a vote and was carried unanimously.

P. E. SUTTON, M.D.: We have concluded the recommendations (exclusive of the recommendations pertaining to the Michigan Medical Service) and I now move the adoption of the report of the Reference Committee on Reports of The Council thus far.

G. C. PENBERTHY, M.D. (Wayne): Second the motion.

The motion was put to a vote and was carried.

XIII—b.-3. COUNCIL'S RECOMMENDATION RE NEW MMS CONTRACTS

P. E. SUTTON, M.D.: The one consideration which has been left out thus far was the matter referred to the joint Reference Committees on Reports of The Council and Medical Service and Prepayment Insurance.

"The Committee reviewed the report contained in the Supplemental Report of The Council having to do with certain changes to be recommended by the House of Delegates to the Michigan Medical Service. The Committee approved the report, and recommends the adoption of the following recommendation:

"(a) That the income limits in the Michigan Medical Service policy be increased to $5,000.

"(b) That the schedule of fees or benefits paid by Michigan Medical Service be increased approximately 40 per cent.

"(c) That Michigan Medical Service provide that all hospital services of physicians, both medical and surgical, be included as benefits.

"(d) That Michigan Medical Service continue all the present forms of contracts affecting the $2,500 income limits."

Most of the men in this room know all of the things that have transpired in the past nine or ten years with respect to dollar value, wage levels and income levels. It appeared to the Committee, as we listened to the evidence, that we have lagged considerably in bringing this particular matter up to date.

Furthermore, it has been considered, recommended and urged upon us for three years (this being the third year), so belatedly the Committee brings this recommendation to you, the first item being that which I have just read, namely, that the Michigan Medical Service policy be increased to $5,000.

The second item is that the schedule of fees for benefits paid by Michigan Medical Service be increased approximately 40 per cent.

May I have the privilege of a bit of explanation and discussion, which may not be the final discussion or explanation. There are others in this room who know much more about the background and the reasons for these things. As it was discussed in the Committee today, it was stated by Mr. Ketcham and Dr. Novy and others who have experience in establishing fee schedules, that while The Council made no recommendation as to the approximate increase of fees, they recommended that the schedule of fees paid by Michigan Medical Service be increased; the Committee added "approximately 40 per cent" with the understanding, of course, as it was stated, that Michigan Medical Service will not suffer a loss. They will have to charge that premium and pay that fee which keeps them solvent, so actually the amount that this fee is to be increased will remain with the Board of Directors of our Michigan Medical Service.

How the figure of 40 per cent was arrived at, I would prefer to have someone else discuss. Dr. Haughey was present, and he can tell us how that figure came in. Dr. Novy is here, and he can tell us something about this figure. There are others here who could tell us about that figure if you desire to question it. The third item is that Michigan Medical Service provide that all hospital services of physicians, both medical and surgical, be included as benefits.

I will not comment on that particular item.

The fourth item is that Michigan Medical Service continue all the present forms of contracts affecting the $2,500 income limits.

If I may comment on this: It might be questioned that it is implied, but I personally believe, as a criticism of this recommendation, that it is implied, but not stated, that there will be two types of fees—that fee paid at the lower level, which it is stated here will be continued to be serviced by Michigan Medical Service, "all the present forms of contracts affecting the $2,500 income limits."

It would be obvious to most of us, and yet it might be a criticism, that you can't keep one level, as far as the income group is concerned, and service it as it is now serviced, and yet agree to the second item, which says that there will be an increase of fees of approximately 40 per cent. There must be a differential. That was implied, and I believe it is obvious; but that question, I am sure, will come up if I do not so state.

The Committee wishes to recommend, and moves the adoption of this report as amended.

C. J. BARONE, M.D. (Wayne): *I second the motion.*

THE SPEAKER: The motion is that the report given us by The Council, as amended, be adopted by the House. That involves the four points—the $5,000 limitation, the approximately 40 per cent increase in fees, the including of all hospital services of physicians, and the continuation of the present $2,500 contract in whatever form it is now being sold.

W. S. REVENO, M.D.: I would like to know whether this matter has been brought up before the Insurance Commissioner. We are operating the Michigan Medical Service under State law, and it is a definite requirement that any changes in the contract must clear with the Insurance Commissioner.

R. L. NOVY, M.D.: This problem has been brought up before to this group; this is the third year. The last year you were here it was brought up, and your consent to an increase was given. At that time we prepared a contract ready to be put into effect. We did not feel we wanted to put it into effect until this group had thoroughly understood the thing, and that is the reason why it is brought up here. That contract has been ready since last October or November, and can be put into force if we wish to do so. That carries a slightly different income limit than this one here.

E. D. SPALDING, M.D.: A point of information, Mr. Speaker. I would like Dr. Novy to clarify two points:

First, what is meant by increasing the limit to $4,000 or $5,000 and still maintaining the $2,500 figure? Are they two policies, or not?

Secondly, I would like to have Dr. Novy make clear (as he has done to me) the fact that if a person in the lower income group goes into a hospital and has a private room and regular nursing round the clock, of his own demand, he therefore takes himself out of that income group, and therefore cannot expect to get complete medical coverage under the low income figure.

R. L. NOVY, M.D.: To reply to your first question, at the present time we have a contract that has a $2,500 family income total. That contract will stay because there are still a great many people in this State whose family income is in that range.

A second contract totally separate from the other will be made available, and it is possible for anyone to take either one. The second contract would say that the income limit is $5,000 and that the fee schedule will be proportionately increased somewhere around 40 per cent over the other. That will be another contract.

That is a contract that you may call a de luxe contract. It is a contract, however, that will cover 80 per cent of the people, the same as the $2,500 contract covered 80 per cent of the people in 1940. They are two separate contracts.

It is necessary to maintain those two, and especially the lower one, for the reason that we are very much concerned about low income people. There are such, and to ask them to pay a premium that would cover the de luxe contract, if I may use that phraseology, would be an injustice to them. Any group would have the opportunity to choose between those two. If they chose the $2,500 group, the status that is now present would be in force.

To come to the second point of your request, and to review what most of you know, there is a limitation on the $2,500, or it would also apply to the $5,000 contract. Those contracts are issued first and foremost for a ward or semi-private two-bed room. They are not issued for any private room. If any individual wishes the luxury of a private room along with the accoutrements that go with a private room, he automatically takes himself out of any income limit classification that he may belong to, and is subject to any charge the doctor sees fit to make. You are all acquainted with that feature.

Repeating it in a slightly different way, your patient is taken to a ward bed. His income is under $2,500. We have agreed that with that low income group we should stand by a fixed schedule of payment. But, say, this man, his family and relatives decide they would like to have him in a private room with a telephone, a bath, and so on. He is moved up to a private room. If his relatives can indulge him in the luxuries of a private room, they automatically take that individual out from under any income limitation, and the doctor has the privilege of charging the fee he wishes. That also would apply to the $5,000 limit.

Is that clear, and does that answer your question, Dr. Spalding?

E. D. SPALDING, M.D.: Your statement is plain, but whether it will stand up or not is another question.

R. L. NOVY, M.D.: It does stand. At the present time on the $2,500 I think those who are present will agree with that.

W. S. Reveno, M.D.: The question I asked a while ago was whether this proposition has been cleared with the Insurance Commissioner, and whether Michigan has thus granted the Michigan Medical Service power to issue two contracts, one limiting the policyholder whose income level is below $2,500, and the other to those whose income has a top limit of $5,000, for the same type of service that is being rendered.

R. L. Novy, M.D.: The $5,000 contract has not been presented. We have had discussions in regard to $4,000. I will have to ask for an exact answer. I see Mr. Ketcham in the back of the room. Can you answer that specifically and exactly?

Mr. Ketcham, the question specifically is this: The $2,500 schedule now in force has been cleared. Has a second one of $5,000 been cleared with the Insurance Commissioner? That first answer, of course, is "No," because that has not been brought up; but a similar one at the $4,000 level was ready to go last fall. What is the answer in regard to clearing that with the Insurance Department?

Mr. Ketcham: There has been no application filed with the Commissioner of Insurance for approval of any other contract than the one now in force. It has been discussed thoroughly, unofficially and off the record, and so far there has been no objection raised to any reasonable contract that we wish to issue, as long as the rate is adequate for the benefits provided.

R. A. Johnson, M.D.: Mr. Speaker, I have a question for Dr. Novy. The comment has been made that this will be a 40 per cent increase in fees. I think that point needs clarification. The fees are pretty much standard, and it is the intent, as I understand it, of this new schedule, to have the new fees approximate current fees, rather than be in actuality a 40 per cent increase in fees.

Will you clarify that point, Doctor?

R. L. Novy, M.D.: That recommendation, of course, is not specific in the sense that it must be 40 per cent. It is obvious that a great deal of study would have to be made in order to determine what is the proper change. It is intended that the fee schedule, as put out for the $5,000 policy, shall be the going charges that are made to that group at the present time, not more and not less.

R. A. Johnson, M.D.: Is that in the resolution?

R. L. Novy, M.D.: That is in the resolution, yes. The 40 per cent was put in the statement with the word "about." They very definitely mean "about." It doesn't mean 20 or 60 per cent, but it does mean somewhere in the neighborhood of approximately 40 per cent.

We have a number of approaches to that, none of which yet to my mind can be accepted as final. I will mention some of the approaches we have: We have had the charges made to a certain employed group in which all the bills that were rendered to that employed group were received, and we could then find out how much they were greater or less than the amount that the Michigan Medical Service currently pays. That is one approach.

We had a second approach that no longer is as accurate as it was, and that is the approach to Genesee County, where the bills from Genesee County were sent direct to the patient and forwarded to us, and we kept those bills and we kept track of the charges that were made. Those bills were a great deal more in the past than they are at present.

We have a third method of approach in the fee schedule that was set for government agencies, recently passed, in which the current rates for government agencies were requested, and the returns came in on that.

The returns from the fee schedule for government agencies were roughly in the neighborhood of 20 per cent higher than the current Michigan Medical Service fee schedules, 20 per cent or slightly better. Forty per cent is definitely higher than the returns we had throughout the State.

May I digress at this point to say that the returns in regard to the uniform fee schedule for government agencies requested from The Council were most gratifying. A large number are replying. The replies in regard to office visits that were sent out supplementary to the first, brought back something more than 2,500 returns. You will recall that the total Society numbers somewhere around 4,400 or 4,500. That return was very striking.

C. J. Barone, M.D.: I would like to call attention to the fact that when you get to the $5,000 limit—you have just heard the statement made that it covers about 80 per cent of the population. Dr. Novy said this noon about 62 per cent. The Committee Chairman said 80.

R. L. Novy, M.D.: I didn't use the figure of 62, sir.

C. J. Barone, M.D.: We won't argue about that. On that percentage of the population you gentlemen are going to be participating physicians and working on a fading fee basis, just the same as you would under a government insurance plan.

R. L. Novy, M.D.: I wonder whether a bit of clarification on that is necessary. I don't see too much doubt on that, and I want that perfectly plain and clear. May I make that clear.

In 1940 approximately 80 per cent of the population had family incomes, group incomes, family group incomes, of $2,500 and less. The dollar has depreciated in value, and you may say your income is greater but you are no richer, even if you count your dollars greater.

Today figures from different sources will vary slightly; the last figures that were available were that there were somewhere between 70 and 80 per cent of the population whose incomes were below $5,000. In fact, the latest figures available on that show a little discrepancy in the sense that there are fewer people below $5,000 today than there were below $2,500 in 1940.

Let me add another point to that: When the $2,500 fee schedule was set, it meant that approximately 16 to 20 per cent of the population was over income, and therefore not covered by the service feature. If this $5,000 income should be put into effect, it would be approximately or close to 30 per cent (the figures I am thinking of give 32 per cent) who would be above income, and therefore not covered by the service feature.

C. K. Stroup, M.D. (Genesee): Would you please amplify your statement that your findings from Genesee refer to the past and not to what is going on now?

R. L. Novy, M.D.: Yes. Some years ago the situation in Genesee County was quite tense in regard to this whole problem. Everybody is aware of that. You are also aware of the many times we have taken gibes at Genesee County, when they would not accept even a check on the Michigan Medical Service and had to have payments made in cash. We have ribbed them a great many times about that, where we had to send cash up with a gun on a man's hip because he was carrying too much of it to dare go into Genesee County without a gun.

In other words, the co-operation in Genesee County was flatly nil. Today that picture has very definitely changed. The co-operation is much, much better. We have doctors participating in Genesee County, a thing that was not true just a few years ago. Correspondingly, the reports coming from Genesee County, while they may not be participating and while they may not have signed their name on the dotted line, while their County may not have taken action, nevertheless they are co-operating in spirit and no longer do we have these reports and the condition that we had before.

At one time there was opposition when the original fee schedule for government agencies came up. We were waited upon by a delegation from Genesee County, consisting of several men who represented certain specialties. One of the things they complained about was that the fee schedule for tonsillectomies was not high enough, that it should be raised more. I forget exactly whether they wanted $35 or $40 for a tonsillectomy. They came down demanding that that be given consideration. I presented to that delegation 2,000 bills from Genesee County that they themselves had rendered to their patients, in which the average of those bills varied from the average arrived at throughout the State by something less than 20 cents. It was $30.

That type of information, because of the increased co-operation, because of the change in attitude, is no longer considered by us as accurate as it was in the beginning. In the beginning it was an excellently accurate judge.

L. J. Morand, M.D.: I don't want to ask any questions because I don't think anybody here can answer the question that is bothering me. I don't think any one of us can know whether there should be a 40 per cent increase, or whether it should go up to $5,000. We have no actuarial evidence or background to know. Time will tell. This is too broad for any one individual or any one group of individuals to prognosticate the outcome.

My thought is this; I am not talking against this, but I am asking myself a question and I want to give you my thought: If we take on up to $5,000 and over $5,000, as a matter of fact, at the actual time, at this sitting we have executors of General Motors who have our insurance or our benefit, although it smells the same to me—however, the fact still remains that we have no limit, and anybody can have a policy in the Michigan Medical Service.

Are we going to take 80 to 95 per cent of our practice on this policy? What is going to happen if we do? Pressure groups may come along—and right now, at the present time, you all know that the coal industry and the steel industry and the Ford industry and the CIO are in process of trying to see what they can wring out of the employers—and, as in the past, probably will be quite successful. What does that mean? Does that mean that maybe later on the pressure groups will say, "Our employers are going to pay for this"?

Last year the federal government promised federal medicine. It didn't get across, but it may get across some other time. Those things have happened with other matters. They happened with prohibition and with the election last year. A lot of money was lost at the last election. It may happen with us.

Are we building up an organization so that it is going to be possible for the federal government to step in and say, "The doctors built this up themselves, and this is what they want"? The pressure groups are going to say, "We have the same doctors, and why should we pay a premium on a policy when our employers will take care of a premium?"

Are we creating a monster that is going to devour us? Are we becoming the rope that is going to hang us? I don't suppose you can answer that, either, but that is my thought, and I wanted to give it to you.

J. A. Witter, M.D. (Wayne): Just as a matter of information (and I am new in the House of Delegates), I would like to know why we as doctors would not be better off to have 80 per cent of our patients in the over-income group, in order that our charges to them can be more fittingly adjusted? It seems well to me to have a policy available (as the present one apparently is) not only to the man with an income up to $2,500, but mainly with people over $2,500 having that same privilege, and the doctors having the privilege of adjusting their charges accordingly.

Why are we complaining about limiting ourselves up to the $5,000 group? Why not leave that base payment that helps out most of the people who come to us? It allows so much if they are over income on their professional bill. It usually covers a good percentage of it.

The people are happy to have that percentage covered, and

rarely mind paying the balance. Why should we limit ourselves by adding another 30 or 40 per cent and saying that this has to cover it? It seems far more flexible as it is, and probably far less expensive to the consumer.

R. L. Novy, M.D.: In 1940 we said that we would cover approximately 80 per cent of the population. Due to the fact that the dollar is no longer the dollar of 1940, we are now covering closer to 20 per cent of the population. We are attempting to do something to prevent government medicine. We are attempting to cover a certain group of the population so that they can prepay for an illness.

All business at the present time (with the exception of the medical business) has developed time payments for commodities that amount to any substantial figure. You buy an automobile on time payments; you buy almost anything on time payments. There is nothing available in the medical profession except this plan to provide time payment for a catastrophe that is going to cost you at least the cost of a secondhand automobile.

We have a service plan to offer. There is no other organization except the medical profession that can offer a service plan. If we are going to offer nothing but an indemnity plan, so much paid, like any indemnity company offers, we had better get out of the cold problem that is before us and let the insurance companies handle it.

We brought forth this idea because the insurance companies were not answering the demand of the public, and the public was turning to government to put in a socialized program that would take care of that over-all cost of large illnesses. We have put in this block; it is very effective; it is effective to the extent that the program that President Truman originally intended to put through has felt the impact of that not only from us as doctors but also has failed to have the pushing support of the unions themselves.

They are not crazy for government medicine, strange as it may seem. They know the dangers that come from it, but they have no alternative between nothing done to arrange prepayment for illnesses, and government. Under those conditions it is easy to push in the government's direction.

We put in this movement in order to block that very effort. We find that what we set out to do in 1940, due to the depreciation of the dollar, has depreciated in what we claim for it, and we are no longer accomplishing what we set out to do. We are coming closer and closer to being nothing more than an indemnity company. I will have nothing to do with an indemnity company, and when we get down to the point that we are nothing but indemnity then let's let the indemnity companies handle it.

Let's carry on. What has happened in the ten years? From 80 per cent covered it has dropped to 20 per cent covered. We have failed by that much to keep up the very thing we started out to accomplish. The very weapon that we developed to block state medicine—the only weapon that has been developed in answer to state medicine has become dulled because we have not recognized that the dollar no longer buys what the dollar did.

Let me say one thing: The man whose income was $2,500 in 1940, and the man whose income today is $5,000, is no richer. They are on the same plane. Each of them can buy the same amount of bread, and no more. It sounds more in dollars, but it is no different in bread.

Douglas Donald, M.D.: One question I would like to ask to clarify this: Up to the $5,000 bracket, and now medical as well as surgical benefits. There never have been any medical benefits before. Being a medical man, I would like to have this more explicit.

R. L. Novy, M.D.: Dr. Donald, you are a good friend of mine and you say there have never been medical benefits? There have been medical benefits for two and a half years.

Douglas Donald, M.D.: Where?

R. L. Novy, M.D.: There are covered at the present time in the State of Michigan about 65,000 people who have medical benefits. Your practice may be among the elite and you don't get it.

The new part of this thing is intended to be offered not as surgical alone, but medical and surgical. That is to say, any patient who goes into the hospital will have a policy covering both medical and surgical—in other words, covering illnesses within the hospital and not restricted to just a surgical setup.

H. C. Hansen, M.D. (Calhoun): Is there any contemplated change to be made in the universal government agencies?

R. L. Novy, M.D.: The State Society last fall, a year ago, appointed a committee to investigate a fee schedule for government agencies, such agencies as the veterans' group, Crippled Children, and so on, and you received circulars on that. We will talk about that a little tomorrow, in some lantern slides I will throw on at that time. That fee schedule has been completed, and complete revision made thereof, and has been turned over to The Council and reported to The Council for their action. It will be printed shortly, I believe.

S. L. Loupee, M.D. (Cass): One more question comes to my mind: Do you propose to continue to offer this service only to groups?

R. L. Novy, M.D.: Is Mr. Goodrich back there? Do you have that chart on the enrollment of individuals throughout the State?

Mr. Goodrich: I will have it in a few minutes.

R. L. Novy, M.D.: While he is bringing it in I will answer that question briefly, and then I will flash on a chart to show you.

Throughout the State we have been progressing from county to county, or groups of counties, or, in some cases, cities, and have been putting on a campaign of several weeks' duration through the newspapers, radio, pulpits, doctors' offices, and whatnot, in various communities, saying that on a certain date the individuals could enroll in Michigan Medical Service. We have given them a period of about a week to enroll after this campaign was originally started.

The campaign was on, a date was set, and such was put on. We had such a campaign here in Grand Rapids a relatively short time ago, a few months ago, and the campaign carried with it local advertisements in the papers, on radios, and maybe the local men can tell me a great deal more about it than I know. It included a banner across the City Hall, in which enrollment was thrown open to individuals.

It is obviously impossible to enroll individuals at quite the same rate that you enroll groups, because of the actuarial difficulties of handling individuals; but it was thrown open to individuals. At the same time we very frankly said, "If you can get together a group of five or more, you can enroll." It requires only a group of five with a common source of income to join.

Here in the city of Grand Rapids that campaign was put on, and the enrollment period occurred for weeks. Out of the city of Grand Rapids, which has in the metropolitan area something in the neighborhood of a quarter million people, I will let you guess for a second how many individuals availed themselves of that opportunity to get it. It was advertised ahead of time by all methods that could be brought to their attention. I hear someone guess 5 per cent. I won't ask for other bids.

Out of a quarter million people in this metropolitan area, 700 people availed themselves of that opportunity!

Covering that same feature, this chart has various colors on it. It shows the area throughout the state where we have offered to individuals this contract by that kind of campaign. The only areas where we have not offered it are shown marked in white; the other areas in different colors represent where we have offered it twice, and some areas in which it is now in the process of being offered.

In some of the areas, such as this big block up in here, we were met by objections to putting it in there by the Commissioner of Insurance because of non-availability of hospitals in some of the areas around there, and they said they would have to go too far to a hospital in order to get it. It would be something like twenty miles. You can cross Detroit's twenty miles very easily, but in the Upper Peninsula twenty miles is considered to be too far to be worked out. I believe that block will be taken care of.

When you say that the Michigan Medical Service hospital and medical plan has not been given to individuals, here is the map that shows it. The white spots are the only spots in the State of Michigan where that has not been offered or is not being offered. The diagonal marks show where it has been offered at least twice.

One other comment along exactly the same line: This is not easily seen from where you are sitting, but it represents the Farm Bureau enrollment, and where that Farm Bureau enrollment is present is shown here by numbers. It is too far away for you to read those numbers, and yet we have definitely covered the Farm Bureaus on that.

S. L. Loupee, M.D.: I wish very definitely to state that I did not infer you have not offered this to individuals. I wanted to know the facts.

R. L. Novy, M.D.: Those were all I was giving to you—the facts.

R. J. Hubbell, M.D. (Kalamazoo): Perhaps Dr. Sutton could enlarge on just one thing. The recommendation of The Council did not include the 40 per cent increase. Why did you elect to include that in your recommendation?

R. L. Novy, M.D.: I would like to have Dr. Ledwidge answer that.

The Speaker: Dr. Ledwidge was chairman of The Council Committee which considered this before writing the report.

P. L. Ledwidge, M.D.: In answering the question which has been asked of me, I would like to give just a little more of the background than has been given here tonight.

It is perfectly true that these things were gone over completely and thoroughly in the Reference Committee. On the other hand, I believe this is a question that is important enough so that every delegate should understand it perhaps a little better than they do now.

In the first place, let's go back to the time when Michigan Medical Service was established. The philosophy behind the establishment of Michigan Medical Service considered really two purposes: First, to do something for the public in the way of supplying health care for what they could afford to pay; second, to do the best we could for the medical profession.

I believe the non-profit organization we have set up has been able to do more for those two groups than any other method that has been considered to date.

First, from the standpoint of the subscriber: Is there any doubt in the mind of any individual here that Michigan Medical Service is more generous to the subscriber than any other type of service that has been offered? Is there any doubt on that point?

Now, from the standpoint of the medical profession: Our organization operates at an administrative overhead of about 12 per cent. I cannot give the average rates of the other groups that furnish service—commercial groups—but it is very, very much higher. Therefore, theoretically, at least, and in practice, I believe, for what the subscriber pays in dollars he gets more service for himself and his family—and certainly the doctor of medicine who takes care of him should get a great percentage of the subscriber's fee paid in. I doubt if there is any company on earth that is paying out 88 per cent of subscribers' premium fees to the doctor. I doubt it.

Now let's go back just a little bit, as Dr. Novy has said, to what our service was set up to perform. It was set up as a service program, in which we would give, after a few months of time—we settled down to hospital service, and we agreed (at least those who participated agreed) to take care of hospital care of these patients for the fee paid by Michigan Medical Service, provided they came within the income limits.

At that time, as has been stated, about 80 per cent of the group came within that limit; now about 20 per cent come within it. In other words, we are acting at the present time, as Dr. Novy said before, as a service organization to about 20 per cent of our total group. For about 80 per cent we are acting as an indemnity company.

Dr. Witter has brought up a very nice point: Would it not be better to keep 80 per cent of our patients as private patients, who would be over the income limit and who would pay us what we feel would be fair and what they think would be fair? Absolutely. It would be better.

Unfortunately, however, we don't have the final say on that. Don't you recall that for at least four or five years there has been a compulsory health insurance plan brought before the Congress of the United States? Don't you recall that in the last Congress the President gave that priority over practically everything else? Why didn't it get farther? It didn't get farther for one reason, I believe, and it is this:

While the large labor groups, such as the United Mine Workers, the UAW-CIO, steel, and so on, are giving lip service to a government program, they don't want it. Why don't they want it? They don't want it right now for this reason: If that goes into effect, the money to pay for it is to come partly from payroll deductions in the form of taxation. They don't want that; they want the worker not to be taxed for this, but to have the employer furnish it.

If they don't get some other type of service plan then they are committed wholeheartedly for government compulsory insurance. I don't think for one minute that government compulsory insurance is the only thing we have to fear, and I don't think for one minute that we are going to stall that indefinitely. We have stalled it for four or five years, and this year it cost our Society approximately $137,000 to do it. Isn't that right, Mr. Palmer? Approximately $137,000! We are not going on that way forever. If we do, we are not going to be able to control it.

Besides the government let's think of one or two things: The UAW-CIO and the other CIO organizations are demanding a service organization, and they are going to get it elsewhere—no doubt about it, in my mind, at least—and they are trying to do it in several ways: They are contacting other groups; they are trying to get commercial companies to give them a service contract; they are trying to get certain hospital groups and clinics to give them a service contract. We have no guarantee that some of those groups will not be willing to do it.

Now may I give one word of explanation before I continue on with what I am going to say: The reason I am here, and the reason the report came to The Council as it did, was because last July, at our Council meeting, there was a request to consider some way of servicing these large groups, such as the United Mine Workers. They have a Health Foundation. I thought it was 10 cents a ton, but some of the boys told me today it is 20 cents a ton assessment on each ton of coal. Don't think they haven't the money, and don't think they are not going to buy service—they are!

On that basis, then, this small committee was set up to study this problem. The committee consisted of Dr. Brunk, Dr. Foster and myself, and Dr. Beck, Chairman of The Council, as ex officio. Don't think we were drooling for the job, because it is neither an easy nor a pleasant one. We met with some of these groups, and we found out certain things which we reported to The Council and which are included in the preamble and in the recommendations.

Now, let's go back for one moment to what we are doing: We are servicing about 20 per cent of the people. In other words, about 80 per cent of those who would come under the new group are over-income and therefore are being charged over the Michigan Medical Service fees.

Suppose, for instance, we simply vote this income limit of $5,000 and say we do no more than we are doing right now. It doesn't make one iota of difference to you or me whether the subscriber is in the $2,500 or the $5,000 group—he is going to pay the complete fees under $2,500. If he is over $2,500 he is going to pay it anyway. It makes no difference that I can see.

Now, suppose, for instance, that these large companies that are establishing foundations—UAW Mine Workers already have it; steel is demanding it, and the automobile groups are demanding it right now from Ford, and very shortly from Chrysler, no question about it,—suppose they get it, and suppose, because of their income limits in this group (and it is paid on a Foundation basis) we would get 100 per cent enrollment and 100 per cent payment on our fees. Is there any reason why we shouldn't go out and offer that large group that pays well, and hold them, rather than go to some organization that the CIO sets up or some other way?

It seems to me that the present thing can't possibly lose or give any harm as it is offered, and that if this other matter does come to pass we will be in a position to take on business and keep it for our private practitioners, which will be the best type of business. It will take care of the average people with a little better than average income, and it will be 100 per cent fees and 100 per cent collections.

Now I will answer the question asked when I took the privilege of going into this long harangue: The 40 per cent—nobody can set that figure. Dr. Novy has told you some of the things that were used to estimate it. The reason it was put in is this: The original study committee, Dr. Brunk, Dr. Foster and myself, felt that if we came before this group or asked The Council to come before this group and suggest a $5,000 income (and that's a lot of money even in these times), this group would want to know something about what they might have reason to expect in changes in fees. Therefore, we did the best we could. We set down what approximately they were charging over income according to the statistics we could get.

Let me carry that a little further: When it was brought before The Council, The Council is pretty wise in studying these things and they deleted the 40 per cent estimate, and just said there would be an increase in fee schedule—and I think they were wise in doing it because nobody could set it.

The Reference Committee then reinstated it so that it would come up here for discussion. I think there would certainly be nobody on our committee, certainly nobody in The Council, certainly nobody in the Reference Committee, who would object to deleting that part from your resolution, and simply saying that we will authorize Michigan Medical Service to make a proper and fair fee adjustment.

THE SPEAKER: What is the pleasure of the House concerning the disposition of this motion? The motion before the House is that the report of The Council, as amended, be approved. I think we understand it completely. Is there any further discussion.?

E. D. SPALDING, M.D.: I don't offer this in any antagonistic way at all, but while we are discussing the economics of this matter, and actuarial figures, the suggested rise from $2,500 to $5,000 coverage is on the basis of the fact that the dollar has been depreciated 50 per cent. In other words, $5,000 today buys what $2,500 bought ten years ago. That is for the patient. Of course, the doctors' dollar is different. The doctors are only going to get a 40 per cent rise instead of a 100 per cent rise.

The motion was put to a vote and was carried.

THE SPEAKER: Dr. Sutton, do you have further resolutions to report?

P. E. SUTTON, M.D.: Mr. Speaker, we have no further resolutions.

We move the adoption of this report by the joint committees as a whole.

The motion was severally seconded, was put to a vote, and was carried unanimously.

XIII—c. REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

J. R. HEIDENREICH, M.D.: This Reference Committee has reviewed the work of all the Standing Committees. It wishes to commend the excellent work of the Committee on Postgraduate Medical Education, particularly its Chairman, H. H. Cummings, M.D., who has carried the load.

The Committee on Preventive Medicine it wishes to commend, and has no suggestions.

The Committee on Rheumatic Fever Control likewise has done a most efficient job, and the Reference Committee wishes to commend it.

The Reference Committee has only a note of commendation to the Cancer Control Committee.

The Maternal Health Committee has done a most efficient job, and we wish to commend it for its good work.

The Venereal Disease Control Committee has given of its time and its effort with good results, and the Reference Committee wishes to commend it.

The report of the Committee on Mental Hygiene has been accepted with the commendation of the Reference Committee, as has been the reports of the Child Welfare Committee and the Committee on Iodized Salt.

The Reference Committee had no suggestion to add to the report of the Committee on Geriatrics except to carry on its good work in this new field.

The Committee on Distribution of Medical Care, at its own suggestion, suggests that other committees that have taken over its work continue to do so.

For the Public Relations Committee, the Reference Committee had only the highest praise, and encourages it to continue to stress the personal contact in the education of the American public. This holds for all its subcommittees—the Committtee on Newspapers, the Committee on Radio, and the Committee on Cinema and on Publications.

The Ethics Committee had no meetings, therefore no comment.

The Reference Committee wishes to commend the Legislative Committee for sustained and excellent work, and wishes to suggest that thought be given to the employment of an analyst to watch all bills introduced into the State and national legislature.

It is the feeling of the Reference Committee that the Industrial Health Committee should be reactivated, and suggests that it cooperate with industry and labor and other organizations of similar objectives in an educational program to the profession of the scope of industrial medicine, the hazards the worker is exposed to, and its probable disease effects, and that it study the standard practice as to contracts, salaries, and stipends, and to transmit this information to the membership of the Michigan State Medical Society through the Journal.

The Committee commends the Committee on Scientific Work for the excellent program of the annual session.

Mr. Speaker, I move that this report be approved as read.

R. A. SPRINGER, M.D.: I second the motion.

The motion was put to a vote and was carried.

XIII—d. THE REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES

G. T. McKean, M.D. (Wayne):

1. *We recommend that the report of the State Veterans Affairs Committee be accepted and that the Committee be discharged.*
I move that the House approval be given to this recommendation.

E. C. Texter, M.D. (Wayne): *Second the motion.*
The motion was put to a vote and was carried.

G. T. McKean, M.D.: *We recommend that the report of the State Interprofessional Committee be accepted and that this Committee be discharged.*
I move this recommendation be approved by the House of Delegates.

R. V. Walker, M.D. (Wayne): *Second.*
The motion was put to a vote and was carried.

G. T. McKean, M.D.: We have a series of four recommendations which require no special comment:
We recommend that the report of the Beaumont Memorial Committee be accepted.
We recommend that the report of the Scientific Radio Committee be accepted with commendation for its efforts, and that this Committee continue its activities.
We recommend that the report of the Advisory Committee to the Woman's Auxiliary be accepted.
We recommend that the report of the Liaison Committee to Medical Assistants Society be accepted.
I move that the House of Delegates accept this report of the Reference Committee.

E. C. Texter, M.D.: Second the motion.
The motion was put to a vote and was carried.

G. T. McKean, M.D.: Your Reference Committee recommends that the report of the Advisory Committee to the National Foundation for Infantile Paralysis be approved with the following change of its first recommendation: We recommend that this paragraph be worded: "That the local Chapters be advised to use their funds to supplement the available private means of the individual afflicted with Infantile Paralysis." (see Page 1513)
Mr. Chairman, I move that the House of Delegates accept this recommendation of the Committee.

Douglas Donald, M.D.: Second the motion.
The motion was put to a vote and was carried.

G. T. McKean, M.D.: We recommend that the report of the Committee on Increase of Medical Students be accepted, and it is recommended that this problem be given further study.
We recommend that the report of the Committee of Six to Study Basic Science Act and Medical Practice Act be accepted and it is recommended that this Committee be instructed to continue its efforts to have the Medical Practice Act and Basic Science Act amended. It is appreciated how much work has been done by this Committee, and it is to be commended.
We recommend that the annual report of the Permanent Conference Committee with Michigan Hospital Association and Michigan Nursing Center Association be accepted.
We recommend that the report of the Liaison Committee with Michigan State Pharmaceutical Association be accepted.
We recommend that the report of the Liaison Committee with Michigan Hospital Association be accepted.
Mr. Chairman, I move that the House of Delegates accept this report in toto.

E. C. Texter, M.D.: I second the motion.
The motion was put to a vote and was carried.

XIII—e. THE REPORT OF THE REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

C. K. Hasley, M.D.: Mr. Chairman and members of the House of Delegates: The Reference Committee on Constitution and Bylaws unanimously approved the resolutions that were introduced to amend the Bylaws this afternoon. I will take them up in order.

XIII—e—1. Bylaws Ch. 8—Sec. 2.

"Whereas, according to the Constitution (Article IX, Section 1) a Vice Speaker of the House of Delegates is one of the six Officers of the Society, aside from the Councilors, and

"Whereas, according to the Bylaws (Chapter 8, Section 2), 'Officers of this Society shall be ex officio members of the House of Delegates, and with the exception of the Speaker of the House of Delegates shall be without power to vote in the House of Delegates,' and

"Whereas, such a Vice Speaker as well as the Speaker are both duly elected delegates representing their County Societies, in contradistinction to the other four Officers, and as such obviously should not be disfranchised; therefore, be it

"RESOLVED: That the Bylaws (Chapter 8, Section 2) be amended by the insertion of the words 'and Vice Speaker' immediately after the word 'Speaker' in this Section."

Chapter 8, Section 2 will then read as follows:
"Officers of this State Society and members of The Council shall be ex officio members of the House of Delegates, and, with the exception of the Speaker and Vice Speaker," and so on.

Mr. Chairman, *I move the adoption of this part of the report.*

Douglas Donald, M.D.: *Second.*
The motion was put to a vote and was carried.

XIII—e—2 By-laws (Ch. 9.—Sec. 12)

C. K. Hasley, M.D.: "Whereas, according to its authority in the By-laws (Chapter 8, Sec. 3), the 1948 House of Delegates subdivided the 1st and 16th Councilor Districts (constituting Wayne County) to create two additional Districts, the 17th and 18th respectively, but did not specifically designate the boundaries of such, and

"Whereas, the local conditions in Wayne County are different from those in other Councilor Districts, it being a large metropolitan area; therefore it is desirable to have the four Councilors representing this area selected at large, and not one from each of four permanently defined districts. In this way the ablest men available in the whole area may be selected, irrespective of their location in the County; and

"Whereas, it is advisable to have this special procedure definitely set forth in the By-laws to avoid any future ambiguity; therefore, be it

"RESOLVED: That the By-laws (Chapter 9, Section 12) be amended by adding to this Section the sentence, 'Wayne County shall constitute four Councilor Districts without permanent set boundaries within that County,' and that the '17th District—Wayne' and '18th District—Wayne' be added to the Councilor Districts listed in this Section."

Chapter 9, Section 12 then will read as follows:
"The following County Societies shall constitute the Councilor Districts of the State. Wayne County shall constitute four Councilor Districts without permanent set boundaries within that County. 1st District—Wayne," and so on; "16th District—Wayne; 17th District—Wayne; 18th District—Wayne."

Mr. Chairman, *I move the adoption of this part of the report.*

T. P. Wickliffe, M.D. (Houghton-Baraga-Keeweenaw): *I second the motion.*
The motion was put to a vote and was carried.

XIII—e—3 By-laws (Ch. 5—Sec. 3-g)

C. K. Hasley, M.D.: "Whereas, there are some Active Members who are desirous of retaining their membership in the Michigan State Medical Society while pursuing postgraduate work, and it is deemed advisable that such members be exempt from the payment of membership dues and shall be classified as Associate Members for the term of their postgraduated work; therefore, be it

"RESOLVED: That paragraph (g) be added to Chapter 5, Section 3 of the By-laws, to read as follows:

"(g) An Active Member, by transfer, for the period of one year while he is temporarily out of practice on account of postgraduate medical studies. This may be renewed upon petition to The Council at its discretion."

Chapter 5, Section 3 then will have the additional paragraph (g) which will read as follows:

"(f) An Active Member," and so on.

"(g) An Active Member, by transfer, for the period of one year while he is temporarily out of practice on account of postgraduate medical studies. This may be renewed upon petition to The Council at its discretion."

Mr. Speaker, *I move the adoption of this resolution.*

R. W. Teed, M.D.: *Seconded.*
The motion was put to a vote and was carried.

C. K. Hasley, M.D.: Mr. Chairman, I now move the adoption of this report as a whole.

C. S. Clarke, M.D. (Jackson): Second.
The motion was put to a vote and was carried.

XIII—f. THE REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS

B. M. HARRIS, M.D.: We have only one resolution to consider.

1. RESOLUTION RE PROPOSED REORGANIZATION OF AMA

"RESOLVED: That the necessary assistance to the leadership in the American Medical Association be provided by action of the House of Delegates of the American Medical Association, creating an Executive Vice President (not necessarily a Doctor of Medicine), assisted by a group of highly trained technical advisers in such fields as economics, public relations, government, political economy, medical education, medical distribution, and others; and be it further

"RESOLVED: That the Michigan delegates to the American Medical Association be instructed by this House of Delegates of the Michigan State Medical Society to present this resolution to the House of Delegates of the American Medical Association; and be it further

"RESOLVED: That all necessary measures be taken to inform other state societies of the wide purposes and intent of this resolution, and that before the next interim meeting, so that favorable support to this resolution may be effected."

Your Committee approves the principle involved, and recommends that this resolution be referred to The Council of the Michigan State Medical Society for Study, with power to act as they deem advisable prior to the interim meeting of the House of Delegates of the American Medical Association in December, 1949.

Mr. Speaker, *I move the adoption of the Reference Committee's report.*

R. E. DUSTIN, M.D. (Lenawee): *Second the motion.*

After discussion the motion was put to a vote and was carried.

B. M. HARRIS, M.D.: Mr. Speaker, I move the adoption of the report of the Reference Committee as a whole.

H. W. WILEY, M.D. (Ingham): I second the motion.

The motion was put to a vote and was carried.

XIII—g. THE REPORT OF THE REFERENCE COMMITTEE ON SPECIAL MEMBERSHIPS

B. T. MONTGOMERY (Chippewa-Mackinac): This is the list of names which I wish to read to you as being submitted by the respective County Societies for *Life Memberships:*

Name	City
1. A. Benjamin Armsbury, M.D.	Marine City
2. Jay J. Brownson, M.D.	Kingsley
3. John E. Cooper, M.D.	Battle Creek
4. Mortimer E. Danforth, M.D.	Detroit
5. A. James DeNike, M.D.	Detroit
6. Robert L. Dixon, M.D.	Caro
7. Wilkie M. Drake, M.D.	Breckenridge
8. Clarence J. Durham, M.D.	Muskegon
9. Charles T. Eckerman, M.D.	Muskegon
10. C. W. Ellis, M.D.	West Olive
11. John W. Evers, M.D.	Flint
12. George A. Ford, M.D.	Detroit
13. I. S. Gellert, M.D.	Detroit
14. Joseph W. Gething, M.D.	Battle Creek
15. Margery J. Gilfillan, M.D.	Battle Creek
16. William A. Grant, M.D.	Milford
17. Burt Francis Green, M.D.	Hillsdale
18. Raymond S. Halligan, M.D.	Flint
19. Arthur F. Harrington, M.D.	Muskegon
20. William H. Honor, M.D.	Wyandotte
21. George B. Hoops, M.D.	Detroit
22. Aura A. Hoyt, M.D.	Battle Creek
23. Gottlieb H. Kaven, M.D.	Unionville
24. William E. Keane, M.D.	Detroit
25. Frederick C. Kidner, M.D.	Detroit
26. George L. Koessler, M.D.	Detroit
27. Harry B. Kyselka, M.D.	Traverse City
28. Martha L. Longstreet, M.D.	Saginaw
29. C. A. Mitchell, M.D.	Benton Harbor
30. L. W. Oliphant, M.D.	Ann Arbor
31. William R. Olmstead, M.D.	Detroit
32. John Walter Orr, M.D.	Flint
33. E. S. Sevensma, M.D.	Grand Rapids
34. G. J. Stuart, M.D.	Grand Rapids
35. George W. Trumble, M.D.	Flint
36. E. R. VanderSlice, M.D.	Lansing
37. Otto Von Renner, M.D.	Vassar
38. Pitt S. Wilson, M.D.	Muskegon
39. Frank C. Witter, M.D.	Detroit

The following names have been submitted for *Emeritus Memberships*

Name	City
1. Jacob H. Burley, M.D.*	Port Huron
2. T. E. DeGurse, M.D.*	Marine City
3. Guy Henry Frace, M.D.	St. Johns
4. Walter D. Ford, M.D.	Detroit
5. Louis J. Hirschman, M.D.	Detroit
6. Willard Monfort, M.D.	Detroit
7. Dean W. Myers, M.D.	Ann Arbor
8. Robert J. Palmer, M.D.	Detroit
9. George Waters, M.D.*	Port Huron
10. William G. Wight, M.D.	Yale
11. W. J. Wright, M.D.	Ypsilanti

*Deceased

Your Reference Committee recommends the acceptance of these memberships, and I so move.

The motion was severally seconded, was put to a vote, and was carried.

B. T. MONTGOMERY, M.D.: The following names have been submitted for *Retired Memberships*:

1. Lewis M. Carey, M.D.	Port Huron
2. Bertha Ellis, M.D.	West Olive
3. Newton H. Greenman, M.D.	Decatur
4. Arthur C. Henthorn, M.D.	St. Johns
5. H. R. Meyer, M.D.	Lansing
6. R. E. Scrafford, M.D.	Bay City
7. R. N. Sherman, M.D.	Bay City
8. M. E. Vroman, M.D.	Port Huron

Your Reference Committee recommends the granting of these Retired Memberships, and I so move.

The motion was severally seconded, was put to a vote, and was carried.

The following names are those which have been submitted for *Associate Memberships:*

Edward R. Doezema, M.D.	Grand Rapids
Marshall J. Feeley, M.D.	Detroit
H. H. Haight, M.D.	Crystal Falls

The following are from Ann Arbor:

Charles W. Aldridge, M.D.	Jack Lapides, M.D.
George N. Aldredge, M.D.	Manuel Levin, M.D.
Arthur W. Allen, M.D.	Robert E. Lloyd, M.D.
William C. Anderson, M.D.	Charles S. Lueth, M.D.
Edwin V. Banta, Jr., M.D.	Ralph D. Mahon, M.D.
Gerhard H. Bauer, M.D.	John E. Maley, M.D.
Edwin G. Bovill, Jr., M.D.	John S. Marshall, M.D.
Harold L. Boyer, M.D.	Kenneth P. Mathews, M.D.
Henry C. Bryant, M.D.	Richard W. Mills, M.D.
William J. Butler, M.D.	Benjamin Moorstein, M.D.
William D. Cheney, M.D.	Merle M. Musselman, M.D.
Donald R. Cooper, M.D.	Sylvester J. O'Connor, M.D.
James E. Coyle, M.D.	William I. Owens, M.D.
William R. Craig, Jr., M.D.	Max H. Parrott, M.D.
L. Reed Cranmer, M.D.	Robert A. Peelor, M.D.
Charles A. Crockett, M.D.	Stanley T. Rolfson, Ph.D.
Arthur M. Dalton, M.D.	George L. Schaiberger, M.D.
William J. Feicks, M.D.	Henry K. Schoch, Jr., M.D.
Robert G. Fish, M.D.	Hyman D. Shapiro, M.D.
Marshall L. Follo, M.D.	Philip W. Smith, M.D.
John K. Fulton, M.D.	Wayne H. Stewart, M.D.
Thomas P. Glynn, M.D.	Robert M. Stow, M.D.
Philip D. Gordy, M.D.	John W. Strayer, M.D.
Arthur E. Gorlick, M.D.	Neil H. Sullenberger, M.D.
Jack R. Gustafson, M.D.	George D. Taylor, M.D.
William D. Harrelson, M.D.	Alden S. Thompson, M.D.
Walter G. Hunsberger, M.D.	Daniel C. Thomson, M.D.
Raymond S. Jackson, M.D.	Arthur C. Tompsett, Jr., M.D.
Payton Jacob, M.D.	Arthur H. Ulmer, M.D.
Robert H. Juzek, M.D.	William F. Weeks, M.D.
Robert D. Kiess, M.D.	Arnold Wollum, M.D.
Walter G. King, M.D.	

Your Reference Committee recommends the granting of these Associate Memberships, and I so move.

The motion was severally seconded, put to vote, and was carried.

B. T. MONTGOMERY, M.D.: Non-Resident Membership: I. J. Beebe, M.D., Lenawee County.

This has been certified by the State Society. The Constitution requires that in order to become a non-resident member the person must be a resident member in the County in which he is practicing. Since Dr. Beebe was certified by our State office to be eligible, we assume he is a member of his own County Society, and we therefore recommend that this membership be granted.

I so move.

C. L. WESTON, M.D.: I second the motion.

The motion was put to a vote and was carried.

B. T. MONTGOMERY, M.D.: Mr. Speaker, I move the adoption of the report as a whole.

The motion was severally seconded, was put to a vote, and was carried.

(The meeting recessed at eleven-fifteen o'clock.)

TUESDAY MORNING SESSION

September 20, 1949

The meeting reconvened at nine-forty-five o'clock, Speaker J. S. DeTar, M.D., presiding. The House went into Executive Session.

* * *

THE SPEAKER: If there is no objection, the Chair will declare that the House will resume the reguular session and will be out of Executive Session.

XIII—h. THE REPORT OF THE REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

1. Relation between Medical Staffs and Hospital Management

L. W. DAY, M.D.: Mr. Speaker, the Reference Committee on Public Relations had one resolution presented to it, and before we were able to act upon it Dr. Fenton, who presented this resolution for our action, appeared before the Committee and asked that his resolution be withdrawn. Therefore no action was taken.

C. J. BARONE, M.D.: I move the report of the Committee be accepted.

The motion was severally seconded, was put to a vote, and was carried.

XIII—i. THE REPORT OF THE REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

O. K. ENGELKE, M.D.: The original resolution that was referred to the Committee on Hygiene and Public Health by Dr. Armstrong was as follows:

1. Uniform Policy in Polio Cases

"Whereas, the local chapters of the National Foundation for Infantile Paralysis pay only part of the cost of polio care, and

"Whereas, good public relations demand a uniform State policy either for full payment or for assistance with Michigan Crippled Children Commission funds; therefore, be it

"RESOLVED: That the Michigan State Medical Society House of Delegates request the Medical Advisory Committee to the National Foundation for Infantile Paralysis to promote the establishment of such uniform policy for financial assistance to polio cases."

The following resolution was offered by the Reference Committee:

"Whereas, the local chapters of the National Foundation for Infantile Paralysis apparently have no uniform policy for the use of their funds, and

"Whereas, confusion and misunderstanding have arisen because of these apparent differences of policy, particularly in regard to payment for medical and hospital care; therefore, be it

"RESOLVED: That the Michigan State Medical Society House of Delegates request the Medical Advisory Committee to the National Foundation for Infantile Paralysis to explore, during the ensuing year, the possibility of securing more uniform local chapter policies for financial assistance to polio cases, and to report to the House of Delegates session in 1950." (see Page 1514)

Mr. Speaker, *I move the adoption of this resolution.*

R. W. TEED, M.D.: *Second.*

The motion was put to a vote and was carried.

O. K. ENGELKE, M.D.: Mr. Speaker, that is the end of the report. I move the adoption of the whole report of this Reference Committee.

R. A. SPRINGER, M.D.: Second.

The motion was put to a vote and was carried.

XIII—j. REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

C. W. COLWELL, M.D. (Genesee): Mr. Speaker and members of the House of Delegates, this statement handed to our Reference Committee concerning the tribute to the late Dr. T. K. Gruber has been amended by our Committee, merely for typographical errors.

1. Testimonial to the late T. K. Gruber, M.D.

"Whereas, the House of Delegates of the Michigan State Medical Society in the death of Thomas K. Gruber have lost an efficient and successful worker for the best ideals of the medical profession, and

"Whereas, Dr. Gruber was one who made a tremendous contribution at the County, State and national level, and

"Whereas, he represented this body as a delegate to the American Medical Association for more than eleven years, and

"Whereas, we are charged with the heavy duty of continuing the effort with now his courage and example instead of his always cheerful and charming presence, and

"Whereas, work for the improvement of the profession is too often thankless and barren of marks of accolades; therefore, be it

"RESOLVED: That we hereby honor his memory with the above statements, and the delegates of this 84th meeting of the House adopt this tribute as a token of our esteem and approbation; and be it further

"RESOLVED: That this resolution be spread upon the minutes, and a suitably embossed copy be presented to his widow as an expression of our loss."

I move, Mr. Speaker, that this be adopted.

The motion was severally seconded, was put to a vote, and was carried unanimously.

2. Report of Commission on Health Care

C. W. COLWELL, M.D.: *Your Reference Committee on Miscellaneous Business recommends the adoption of the report of the Commission on Health Care, with the deletion of the last paragraph, which reads as follows:*

"Through the studies and observations of your Commission on Health Care, we believe we can state unequivocally that the broad base of the pyramid upon which health care in America should rest will not be as stable as it could be if an Executive Vice President of outstanding potentialities, together with a strong cabinet of specialists in the fields of economics, of science, of law, education distribution and public relations, are not provided to assist the officers and Trustees of the American Medical Association in their very great responsibilities, which burden without adequate assistance they have borne voluntarily through the years."

Your Reference Committee feels that the subject matter covered in the above paragraph was considered in a resolution referred to another committee.

I move, Mr. Speaker, that this be adopted.

The motion was seconded, put to a vote, and was carried.

C. W. COLWELL, M.D.: I move the adoption of the report of the Reference Committee as a whole.

O. K. ENGELKE, M.D.: Second.

The motion was put to a vote and was carried.

XIII—b. REFERENCE REPORTS ON REPORTS OF THE COUNCIL

2. Dispensing of Eyeglasses

P. E. SUTTON, M.D.: The Reference Committee has reconsidered The Council's recommendation that the House of Delegates give study to clarify the conflict between the American Medical Association interpretation and the 1948 Michigan State Medical Society House of Delegates resolution on the subject of dispensing of eyeglasses.

The Reference Committee recommends that the wording be changed to read that the House of Delegates give study to clarify the conflict between the AMA Code of Ethics, as contained in Section 6 of the AMA Code of Ethics, and the resolution passed by the 1948 Michigan

State Medical Society House of Delegates on the subject of rebates and dispensing of eyeglasses.

It is the opinion unanimously of the Reference Committee that this House of Delegates intends and believes in and subscribes to conforming with the AMA Code. Without questioning the upright intentions of this House of Delegates in passing a resolution at its annual meeting in 1948 in direct conflict with this Code, this Reference Committee does not see how it can do otherwise than to recommend the adoption of The Council's recommendation and add its own recommendation of subscribing and conforming to the AMA Code.

For the purpose of clarification for those of you who have not read either of these Articles which appear in conflict, I shall read these two Articles. Section 6 of the AMA Code of Ethics has to do with patents, commissions, rebates and secret remedies.

Section 6: "An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods of procedure. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public, or the medical profession.

"The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients, is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee, specifically announced to his patient at the time the service is rendered, or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

"The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition or the manufacture or promotion of their use, is unethical."

That is Section 6 of the Code of Ethics of the American Medical Association.

Let me now read to you the resolution passed in 1948 by this House of Delegates.

"Whereas, we propose to continue to conduct the practice of medicine according to the experience and judgment of a responsible medical profession working from the scientific, sociological and economic angles, according to plans based on experience, to increase the distribution of good care, and

"Whereas, the Michigan State Medical Society is in the habit of looking at its problems squarely, fearlessly, honestly, and by analysis, and

"Whereas, after analysis, to approach new methods as scientific men should, by planning and experimentation, knowing that the complicated subject of economics in any segment of medicine cannot suddenly be changed by a single formula or law, and

"Whereas, according to the principles of medical ethics it is unprofessional to accept rebates on prescriptions, appliances or perquisites from attendants who aid in the care of patients, we believe it will be the consensus of the House of Delegates that the membership of the Michigan State Medical Society and of the medical profession in general is as honest and as much to be trusted in all of its responsiblities as any other group of citizens, therefore be it

"RESOLVED: That it is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem, not to be separated from the eye examination.

"That we urge that the ophthalmologists accept the responsibility involved in the proper merchandising of glasses to their patients."

Mr. Speaker, the Reference Committee moves the adoption of the recommendation of The Council, with the addition of the Reference Committee's recommendation of subscribing to and conforming to the AMA Code.

THE SPEAKER: Dr. Sutton, would you read again, then, what you are moving? You are moving the adoption of the recommendation of The Council. Would you read again the recommendation of The Council?

P. E. SUTTON, M.D.: We have changed the wording of the recommendation of The Council, and this is the wording we would like to have adopted:

"That the House of Delegates be instructed to give study to clarify the conflict between the AMA Code of Ethics as contained in Section 6 of the AMA Code of Ethics, and the resolution passed by the 1948 Michigan State Medical Society House of Delegates on the subject of rebates and dispensing of eyeglasses," with the addition of the recommendation of the Reference Committee that we subscribe to and conform to the AMA Code.

I have already made the motion, and will repeat that we move the adoption of this recommendation as added to by our Reference Committee and as just now read.

THE SPEAKER: The motion has been made and seconded, and is now open for discussion. The motion is that the House of Delegates make a study (which has been done already by this Committee), and that the House of Delegates subscribe to the ethical principles laid down by the American Medical Association in this matter.

After full discussion P. L. Ledwidge, M.D., offered the following substitute motion:

"That it is the consensus of opinion of this House that no conflict exists between the AMA Code of Ethics and the resolution passed by this House last year."

The motion was severally seconded.

THE SPEAKER: The substitute motion is to the effect that there is no conflict between the resolution passed by this House last year and the AMA Code of Ethics.

The vote is 65 to 21, and the motion is passed. We are therefore agreeing that there is no conflict between the resolution and the AMA Code of Ethics.

L. W. Christian, M.D.: I move that this whole matter be referred to the Judicial Council of the American Medical Association for interpretation.

E. C. TEXTER, M.D.: *I support that motion.*

The motion was put to a vote and was carried by a vote of 65 to 22.

P. E. SUTTON, M.D.: *I move that the report in toto be adopted.*

R. A. SPRINGER, M.D.: *Second the motion.*
The motion was put to a vote and was carried.

XIII—c. REPORT OF THE REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

C. K. HASLEY, M.D.: Mr. Speaker and members of the House, the supplementary report consists of two parts. First there is a petition; second, there is a resolution. I will read the petition:

4. Petition to Create 19th Councilor District

"Genesee County has become one of the large component parts of the Michigan State Medical Society, and under the present organization there are times, covering a period of five or more years, when its Councilor does not live within the boundaries of the County, but in some other part of the District.

"Flint, being the second largest automobile manufacturing center in the World, has developed a situation where its problems of public relations with the laboring class is quite different from that of rural or less industrialized areas, and requires close contact with our State officers at all times. A local Councilor who understands our mutual problems could best serve our interests and those of the State Medical Society in its effort to maintain the best of relations with the public.

"Therefore, the Genesee County Medical Society hereby petitions the House of Delegates of the Michigan State Medical Society to set aside the entire County of Genesee as the 19th District, with a Councilor of its own."

The resolution reads as follows:

5. Survey of MSMS Councilor Districts

"Whereas, it is apparent from time to time that certain of the larger county medical societies are not represented on The Council nor in direct contact with the officers of the State Medical Society, and

"Whereas, we believe a more cohesive working unit could be secured by having every large county unit represented on The Council at all times, and

"Whereas, this cannot now be accomplished and still maintain adequate representation from the less populous areas; therefore, be it

"RESOLVED: That a special committee be appointed to study the possible regrouping of counties in Councilor Districts, to attain better representation of the larger societies, and report their findings at next year's House of Delegates."

The Reference Committee met and felt there was a little bit of confusion. We have a petition which asks that we immediately set up another Councilor District. The resolution, in turn, comes in and asks that a committee be appointed to study it.

The Reference Committee feels that it is neither the right time nor is it suitable to take these things into consideration, and they have therefore drafted this report:

"Your Reference Committee on Constitution and Bylaws has carefully considered the petition and resolution which were introduced by the Genesee delegates. After due and deliberate study with Councilors and consultants, the Committee feels that the problems which confront the Genesee members should be solved locally. The Reference Committee recommends that the petition be not granted, and that the resolution be not approved."

THE SPEAKER: You have heard the recommendation of the Reference Committee.

R. W. TEED, M.D.: I second the motion.

THE SPEAKER: This is not a motion—this is simply a recommendation. Therefore, the Chair will consider that the resolution is on the floor for discussion. The resolution is to the effect that a special committee be appointed to study the regrouping.

Is there any discussion?

C. W. COLWELL, M.D.: Do I take it that you will take up the petition at a later date, after this is settled?

THE SPEAKER: I think the petition ought to be studied with the resolution.

C. W. COLWELL, M.D.: A point of order. Would the petition take preference over the resolution, inasmuch as it was presented first?

THE SPEAKER: The petition does not have status as a motion on the floor. The petition was simply sent along with the resolution, which constitutes a motion. No action is justified on the petition, unless someone from the floor makes a motion on either the petition or the resolution.

As it stands now, there is a resolution before the House for adoption or refusal, and that is to set up a committee to study it.

C. W. COLWELL, M.D.: It was our intent that the petition and the resolution should be considered separately when submitted. I raise that as a point of order.

THE SPEAKER: If that is the desire of those who made the resolution and the petition, then let's consider them separately. The Chair will declare that at the present time we are discussing the resolution. If the presenter of the petition cares to discuss that after the resolution, the Chair will open that after the resolution.

C. W. COLWELL, M.D.: Discuss the petition separately from the resolution?

THE SPEAKER: That is right. Let's discuss the resolution, which is to the effect that a special committee be set up to study a regrouping, with the idea of giving Genesee better representation. The motion is before the House. Is there any further discussion on whether or not to set up a committee to study it? If not—

E. D. SPALDING, M.D.: I would like to have the Chairman of the Reference Committee read the recommendation of his Reference Committee again.

C. K. HASLEY, M.D.: The recommendation of the Committee is that the resolution be not approved.

THE SPEAKER: That is the recommendation of the Reference Committee. The Chair will therefore call for a vote, asking for all those who are in favor of the resolution to vote "yes," and all those opposed to vote "no." If you follow along with the Reference Committee, you will vote "no." They recommend a "no" vote. Is there further discussion on the resolution? If you vote "yes" you are in favor of appointing a committee to study it.

R. J. ARMSTRONG, M.D.: Does the resolution call for a study of regrouping over the State?

THE SPEAKER: Will you read that part of it, Dr. Hasley?

C. K. HASLEY, M.D.: No, the resolution does not call for restudying over the State. It calls just for the restudying of the situation in Genesee County.

If I may make a couple of remarks: If we establish a precedent like this, we are immediately going to have to consider the fact that Kent County has five delegates and would be entitled to another Councilor; Oakland County, with five delegates, would likewise come along and ask for another Councilor; Washtenaw County would do the same thing with its five delegates; Genesee has four delegates, and in addition to that it has 208 members. Clinton and Shiawassee would have one Councilor for approximately fifty or sixty members, with two delegates. Genesee would have a Councilor with four delegates.

C. W. COLWELL, M.D.: Mr. Speaker, I am slightly confused; however, it is our intention to have this petition taken up and discussed separately.

THE SPEAKER: That is right.

C. W. COLWELL, M.D.: The resolution, which I understand you are taking up first, was merely our way of trying to straighten out something of this nature in the future.

THE SPEAKER: There is a motion before the House. If the House would prefer to discuss the petition first, you may lay the resolution on the table and go ahead with the discussion of the petition. Right now the vote before the House is whether to pass the resolution asking for a commission to study this.

R. S. BREAKEY, M.D.: The question was asked as to whether this resolution considered a study of regrouping throughout the State. I was a member of the Resolutions Committee, and it did suggest a study throughout the State. It did not pertain to Genesee County alone. It pertained to Genesee County, but the petition referred to State-wide distribution. There should be no confusion between the two. They are separate.

C. K. HASLEY, M.D.: In order to clarify this, I will read the resolution in its entirety:

"Whereas, it is apparent from time to time that certain of the larger county medical societies are not represented on The Council nor in direct contact with the officers of the State Medical Society, and

"Whereas, we believe a more cohesive working unit could be secured by having every large county unit represented on The Council at all times, and

"Whereas, this cannot now be accomplished and still maintain adequate representation from the less populous areas; therefore, be it

"RESOLVED: That a special committee be appointed to study the possible regrouping of counties in Councilor Districts, to attain better representation of the larger societies, and report their findings at next year's House of Delegates."

THE SPEAKER: That is a general term—a special regrouping of counties in Councilor Districts. Is there further discussion?

W. S. REVENO, M.D.: What is the Committee's recommendation on that?

C. K. HASLEY, M.D.: The Committee's recommendation is that they should not be granted at the present time.

W. S. REVENO, M.D.: We are voting on the Committee's recommendation. A "yes" vote means "no."

THE SPEAKER: No, we are not. We have accepted the recommendation of the Committee. That is not a motion. We are voting on the original motion, to establish a committee to study. We have simply heard the recommendation of the Committee. If you side with the Committee, vote "no." If you are in favor of a committee to study the regrouping of county societies and Councilor Districts, vote "yes." Is there any further discussion?

If not, all in favor say "aye"; opposed, "no." I think we will have to have a division. All in favor please arise. This is a vote in favor of appointing a committee to study the regrouping of Councilor Districts.

All those opposed to the motion, please arise. This means that you are siding with the Committee and you are not in favor of appointing a study committee.

The vote is 29 in favor and 51 opposed. The motion is lost and the resolution is lost. (See Page 1527)

Do you have a further report, Dr. Hasley?

C. K. HASLEY, M.D.: We have the petition.

THE SPEAKER: Dr. Hasley will report on the petition. The petition was sent to his Committee, and it is the duty of the Committee to report back.

C. K. HASLEY, M.D.: The Reference Committee recommends that the petition be not granted.

THE SPEAKER: The petition is for Genesee County—will you repeat that again, so we will know?

C. K. HASLEY, M.D.: The petition would mean that Genesee County thereby petitions the House of Delegates of the Michigan State Medical Society to set aside its entire County of Genesee as the 19th District, with a Councilor of its own.

THE SPEAKER: You have heard the petition. Dr. Hasley has reported the recommendation of the Reference Committee as being not in favor of granting the petition.

E. D. SPAULDING, M.D.: Mr. Chairman, I move you that the petition be not granted.

P. E. SUTTON, M.D.: Second the motion.

C. K. COLWELL, M.D.: For the purpose of the record, Mr. Speaker, and on behalf of our present Councilor, I would like to say a few words.

I would like to thank the Committee for allowing us to appear before them. They were very gracious indeed. At the same time, perhaps they don't understand our problems. We feel, as I believe other large industrial metropolitan areas do, that our problems cannot be properly brought before the Michigan State Medical Society unless the Councilor lives within that particular District.

We have an excellent Councilor; I hope he is here. Unfortunately for us, he does not live within our home town, and we don't believe he can see our problems. It is physically impossible for him

to spend enough time in our hospitals to see those problems as he would like to see them.

Last year another county asked for two delegates, and we feel that they did that so that they could better become acquainted with the problems of the Michigan State Medical Society.

THE SPEAKER: Is there any further discussion on the motion?

E. D. SPALDING, M.D.: Mr. Chairman, it is perfectly possible for Flint to have all the representation it wants, by selecting a Councilor who lives more centrally located and not twenty miles to the west.

C. W. COLWELL, M.D.: One more word, Mr. Speaker: That is perfectly possible in the future, but at the present time it is not possible, and we do not wish to do away with our Councilor at the present time. The other large metropolitan areas, we have been informed, feel exactly the same as we do, except that at the present time they do have a Councilor within the confines of their own home town, shall we say. We are the ones who are affected at the present time, and that is the reason why we are asking for this Councilor and the 19th District.

THE SPEAKER: The motion is that the petition be not granted. Any further discussion? If not, all in favor of the motion that the petition be not granted—in other words, if you vote "yes" you are in favor of not granting this petition—say "aye." Opposed, "no." The motion is passed and the petition is not granted.

C. K. HASLEY, M.D.: I move the adoption of the report as a whole.

The motion was severally seconded, was put to a vote, and was carried.

(The meeting recessed at twelve o'clock noon.)

TUESDAY EVENING SESSION

September 20, 1949

The meeting reconvened at eight-thirty o'clock, Dr. J. S. DeTar, Speaker of the House, presiding.

XIII—c. REPORT OF REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

5. Survey of MSMS Councilor Districts.

R. S. BREAKEY, M.D.: Having voted on the negation concerning this, I move that the resolution be reconsidered.

W. S. REVENO, M.D.: I second the motion.

THE SPEAKER: It has been moved and seconded that the resolution be reconsidered. The Chair will ask the Secretary, who is in possession of the motion, to come to the microphone and read the resolution which is under reconsideration.

SECRETARY FOSTER: The resolution as presented from the Genesee County Medical Society through its delegate, F. W. Baske, M.D., is as follows:

"Whereas, it is apparent from time to time that certain of the larger county medical societies are not represented on The Council nor in direct contact with the officers of the State Medical Society, and

"Whereas, we believe a more cohesive working unit could be secured by having every large county unit represented on The Council at all times, and

"Whereas, this cannot now be accomplished and still maintain adequate representation from the less populous areas; therefore, be it

"RESOLVED: That a special committee be appointed to study the possible regrouping of counties in Councilor Districts to attain better representation of the larger societies, and report their findings at next year's House of Delegates."

THE SPEAKER: Is there any discussion on the motion to reconsider the resolution? We are debating whether to reconsider the resolution.

The Chair is in doubt. Will the Secretary please announce the vote?

Those in favor of reconsideration, say "aye"; opposed, "no."

SECRETARY FOSTER: 41 to 38.

THE SPEAKER: *Forty-one are in favor of reconsideration and thirty-eight are opposed. The question is now open for reconsideration, and the motion before the House is the resolution.*

The resolution before the House is whether or not we shall appoint a committee (that will be a Council committee) to study regrouping of counties and Councilor Districts to attain better representation of the larger societies, and to report their findings at next year's House of Delegates.

The motion was put to a vote and was carried.

XIV. ELECTION OF OFFICERS

XIV—a. COUNCILOR 14th DISTRICT

First is the election of a Councilor for the Fourteenth District. Dr. Dean W. Myers of Ann Arbor is the incumbent in the Fourteenth District. The Chair will open nominations for Councilor of the Fourteenth District.

DEAN W. MYERS, M.D. (Washtenaw): Before I proceed to this nomination I would like to state to this Society that I appreciate, more than my English will permit me to express, the honor that you have conferred upon me in making me your Councilor, which position I have held for the past seven years. I am withdrawing voluntarily from The Council, and I have the name of a man to present who I think will give you a fine administration.

He will bring to The Council a spontaneity, a knowledge of the affairs of the State Society, a loyalty that is not exceeded by any others. It will bring to The Council a man of whom you are all very fond, I know. I don't want to take any more of your time.

I wish to present the name of Dr. John S. DeTar, of Milan.

(Vice Speaker Baker resumed the chair.)

R. W. TEED, M.D.: Mr. Chairman, on behalf of the delegates from Washtenaw, Livingston, Monroe and Lenawee I would like to second this nomination.

VICE SPEAKER BAKER: You have heard the nomination of Dr. DeTar for the Fourteenth District. Are there any other nominations?

R. A. SPRINGER, M.D.: Mr. Chairman, I move that the nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. DeTar.

R. W. TEED, M.D.: I second the motion.

The motion was put to a vote and was carried.

CHAIRMAN BAKER: Dr. DeTar, you are now Councilor—but you are still the Speaker. Will you step back to the rostrum?

(The Speaker resumed the Chair.)

THE SPEAKER: Gentlemen, I don't know how to thank you, but I assure you it won't be long before I will have only one position. The job of Councilor carries with it many responsibilities, and I assure you that I will do my best to enforce those responsibilities and carry them out.

XIV—b. COUNCILOR 18th DISTRICT

Next is the election of a Councilor for the Eighteenth District. Dr. William Bromme, of Detroit, is the incumbent. Nominations are now open for Councilor of the 18th District.

R. V. WALKER, M.D.: Mr. Speaker, it is my pleasure to nominate a man who only recently has become a member of The Council, whose term expires, and who I am sure will prove to be of great value to The Council if he can succeed himself.

I nominate Dr. William Bromme.

THE SPEAKER: Are there other nominations?

J. A. WITTER, M.D.: I move that nominations be closed and that the Secretary cast the unanimous ballot.

ARCH WALLS, M.D. (Wayne): I second the motion.

R. A. JOHNSON, M.D.: Mr. Speaker, I move that on Dr. Bromme's nomination we incorporate the words "for a five-year term."

The motion was severally seconded.

THE SPEAKER: The Chair will recognize a motion, and this motion will take priority over the nomination, in order to keep the record straight.

The motion before the House is that the nomination is effective for a five-year term.

The motion was put to a vote and was carried.

THE SPEAKER: Nominations are still open for Councilor from Wayne County for a five-year term. Dr. William Bromme has been nominated.

A motion that nominations be closed was severally seconded.

The motion was put to a vote and was carried.

XIV—c. DELEGATES TO AMA

Nominations are now declared open for delegates to the American Medical Association. According to the Constitution which was adopted last year, any number of nominations may be made from the floor of the House for the number of delegates to be elected. This year there are three delegates to be elected to take the places of Dr. L. G. Christian of Lansing, incumbent; Dr. W. A. Hyland, of Grand Rapids, incumbent, and Dr. T. K. Gruber, deceased.

H. W. WILEY, M.D. (Ingham): It is my privilege as a member of the Ingham County Medical County delegation to place in nomination a man who has served our County and this State Society well for many years. He is a Past President of the Ingham County Medical Society, a delegate to the American Medical Association from this State Society for several years, and at the present time since the death of our beloved Thomas Gruber, the senior member of the delegation to the American Medical Association.

For ten years he has been a member of the Social Welfare Commission of the State of Michigan, and at the present time is its Chairman. I should like to place in nomination the name of Leo G. Christian of Ingham.

W. D. BARRETT, M.D.: Mr. Speaker a point of order: Dr. Gruber's term would have been one year from now. I think we are electing two, and electing one for an unexpired term.

THE SPEAKER: Dr. Foster is looking up the point right now. Thank you very much, Dr. Barrett. Apparently we are electing two delegates for a full term, and one delegate for a one-year unexpired term.

The Constitution indicates that the delegates will be selected in accordance with the number of votes cast, so in all probability we will vote on all of them at once. We are not voting on anyone to replace Dr. Gruber; we are voting on delegates to the American Medical Association. We will have a ruling on that from the Secretary very shortly.

The name of Dr. Christian has been recorded as a nominee.

Dr. Foster has found the ruling. There is some question as to whether, according to the new Constitution, the man receiving the third highest number of votes will serve out the unexpired term of Dr. Gruber. Dr. Foster is now looking that up.

The Chair would like to read from the new Constitution the ruling on the election of delegates, on page 127 in your Handbook:

"At each annual election, candidates for delegates to the House of Delegates of the American Medical Association shall be nominated in number equal to or greater than the number to be elected that year. Election shall be by ballot. The required number of high candidates shall be declared elected."

That is all there is in the Constitution. There is nothing in the Constitution to handle the problem of electing a delegate for an unexpired term. Therefore, the Chair will declare this procedure to be followed, if it is agreeable with the House:

We will make nominations for the two terms which are expiring this year, to succeed Dr. Christian and Dr. Hyland. After that election is held we will hold an election for a man to succeed Dr. Gruber for a one-year unexpired term, unless you prefer to hold the election all at once and have the first and second highest take the full terms and the third man take the unexpired term.

What are the wishes of the House?

E. D. SPALDING, M.D.: Mr. Speaker, I move that the House sustain the decision of the Chair.

R. S. BREAKEY, M.D.: Second the motion.

The motion was put to a vote and was carried.

THE SPEAKER: The Chair will then decide that we will hold an election for the two men who will be elected for the two full terms, and thereafter will elect a man for the unexpired term of Dr. Gruber.

Nominations are now open for the two full terms for delegates to the American Medical Association.

W. B. MITCHELL, M.D.: Mr. Speaker and members of the House of Delegates, I would like to make the nomination of a man who has been in the office and has carried on as delegate from Michigan. I would like to nominate William A. Hyland, M.D., to succeed himself as delegate to the American Medical Association.

THE SPEAKER: Dr. Hyland has been nominated. Are there any other nominations?

P. L. LEDWIDGE, M.D.: I would like to second that nomination.

T. J. KANE, M.D. (Muskegon): Mr. Speaker, inasmuch as I understand the decision of the Chair is to vote for the two nominees for the full terms first, rather than by the other method once suggested, and there having been two nominations made, I should like to move that the nominations be closed.

The motion was severally seconded, was put to a vote, and was carried.

THE SPEAKER: The Chair will direct the Secretary to cast a unanimous ballot for the two nominees.

The Chair will now declare nominations in order for the position of delegate to the American Medical Association to replace Dr. Thomas K. Gruber, deceased, for the unexpired term of one year.

GROVER C. PENBERTHY, M.D. (Wayne): Mr. Speaker and members of the House of Delegates, it is hardly necessary for me to enter this candidate before you, but I wish to make mention of the fact that the delegates from Michigan have always sent strong delegates to the AMA. They include in our present group Drs. Hirschman, Luce, Reeder, and our deceased member, Dr. Gruber, to mention only a few.

It is important that we maintain a high standard of delegate. Our present delegates to the AMA are outstanding in their activities pertaining to the work of the AMA. I have not been a delegate from the State of Michigan, but for some eight years I worked with the delegates from the State of Michigan as a representative from the Section on Surgery, and I wish at this time to place in nomination an individual you all know and whom I am sure you all respect, none other than Dr. Robert L. Novy.

We are at a point in medical history where the good advice and the good counsel of one such as Dr. Novy will be very valuable not only for the State of Michigan but for the United States.

It is a great pleasure and privilege to have this opportunity to present the name of Dr. Robert L. Novy to succeed our beloved deceased member, Thomas K. Gruber.

THE SPEAKER: Dr. Novy has been nominated. Are there further nominations?

W. D. BARRETT, M.D.: I would like to support the nomination of Dr. Novy.

J. D. VAN SCHOICK, M.D. (Jackson): I would like to move that the nominations be closed and that the unanimous ballot be cast for Dr. Novy.

R. A. SPRINGER, M.D.: Second the motion.

The motion was put to a vote and was carried.

XIV—d. ALTERNATE DELEGATES TO AMA

THE SPEAKER: We will open nominations for alternate delegates to the American Medical Association.

The alternate delegates to the AMA are Dr. R. A. Johnson, of Detroit, incumbent, and Dr. H. H. Cummings of Ann Arbor, incumbent.

E. D. SPALDING, M.D.: Mr. Speaker, I would like to place in nomination for alternate delegate to the AMA the name of Dr. Clarence L. Candler, recently elected treasurer of the Wayne County Medical Society.

W. D. BARRETT, M.D.: I would like to place in nomination the name of Dr. Elmer Texter, of Wayne.

THE SPEAKER: Are there other nominations? We have two alternate delegates nominated.

THE SPEAKER: We have two full terms of two years for election, and one unexpired term of one year. Therefore, if it is agreeable with the House, the Chair will declare nominations open. We have had two nominations, Dr. Candler and Dr. Texter, for the two two-year terms. We will leave the one one-year unexpired term for the nominations later.

R. S. BREAKEY, M.D.: Mr. Speaker, I should like to submit in nomination the name of Dr. Ralph Johnson, who has served as an alternate over a period of several years, to succeed himself.

R. A. JOHNSON, M.D.: Mr. Speaker, I would like to take my name off as a candidate. I will quote you General Sherman's remark: "If nominated, I will not run. If elected, I will not serve."

THE SPEAKER: A man like Dr. Johnson appears rather definite. The Chair has no alternative except to withdraw the name of Dr. Johnson.

R. W. TEED, M.D.: Mr. Chairman, I would like to submit the name of Dr. H. H. Cummings for nomination as alternate.

THE SPEAKER: The name of Dr. H. H. Cummings has been submitted. We are voting on two positions and we have three nominees. Are there any other nominations?

T. J. KANE, M.D. (Muskegon): I would like to move that nominations be closed.

R. A. SPRINGER, M.D.: Second the motion.

The motion was put to a vote and was carried.

THE SPEAKER: The Chair will now appoint the tellers: Dr. Walter S. Stinson, Chairman; Dr. Springer, Dr. Walls, Dr. Breakey, Dr. Loupee and Dr. Lightbody. Will you please pass the ballots?

You are voting on the names of Drs. Candler, Texter and Cummings. Please vote for two. The two highest will be selected as alternates to the American Medical Association. Please put both names on one ballot.

(Balloting.)

XV. WILFRID HAUGHEY, M.D., BATTLE CREEK, "PRESIDENT FOR A DAY"

THE SPEAKER: While you are voting, gentlemen, the House of Delegates has elected one member of the Michigan State Medical Society to an honorary position as "President For A Day,'" which is to be Wednesday, Sept. 21, 1949. I should like to ask Dr. Wilfrid Haughey to come and sit with us, because he is President of the Michigan State Medical Society for a day.

(The audience arose and applauded.)

THE SPEAKER: While we are counting the ballots I would like to call a man to this platform who was Speaker of the House of Delegates from 1942 to 1946, a five-year term. He was President-elect in 1947; he was President in 1948, and now he is Past President but he is not consigned to the limbo of the dead. This man has been a rock of Gibraltar on The Council and the Executive Committee. He has been a wheel horse of labor, for organized medicine for many years. For instance, he has been Chairman of the Committee to Study the Health Plans; he has been on the committee which wrote the present Constitution; he has been Chairman of the Committee to Study the Basic Science and the Medical Practice Act. He has been on the Board of Michigan Medical Service for many years. He has been chairman of the committee which definitely solved the problem of the non-participation of some very important hospitals in Michigan Medical Service.

The Michigan State Medical Society would not be what it is today if it had not been for the services of one of our Past Speakers, P. L. Ledwidge, M.D., and I want him to come up here and sit down with us.

The audience arose and applauded.

THE SPEAKER: Pat doesn't talk much, but I am going to ask him to say just a word.

P. L. LEDWIDGE, M.D.: May I say two? Thank you.

THE SPEAKER: Are the tellers ready? You know, last year or the year before we introduced several of the Past Presidents. With the number of new delegates we have here who have not met some of our older officers, I think it would be most interesting if they did.

I would consider it so if I were in my first year in the House of Delegates, and so I want to call another of the older men (and I am not dealing in Past Presidents now), a past Speaker of the House. Is Phil A. Riley, M.D., here? Well, Phil Riley isn't here, but I have a man of approximately the same shape but of a few more years.

I want to ask one of our Past Speakers to come to the platform. He was Speaker of this House a long time ago—about the time some of our delegates were getting out of high school. I believe it was in 1936-37. He was delegate to this Society in the House of Delegates for thirty years. He was delegate to the American Medical Association for eleven years, and he has never missed a session of the House of Delegates of the Michigan State Medical Society in the last thirty years—and that's a remarkable record, gentlemen.

This man's hobby has been parliamentary law. He was Sergeant-at-Arms of the House of Delegates of the American Medical Association for ten years. Not only that, but his main claim to fame was that he was brought to the University of Michigan by Coach Yost, and at one time he roomed with Branch Rickey. I want former Speaker T. E. Reeder, M.D., to come to the platform.

F. E. REEDER, M.D. (Genesee): Mr. Speaker, thirteen years ago I was appointed Sergeant-at-Arms, and with your permission I would like to have J. J. O'Meara, M.D., escort me there.

The audience arose and applauded.

THE SPEAKER: Dr. O'Meara, will you please come forward? For many, many years, Dr. J. J. O'Meara of Jackson has been Chairman of the Credentials Committee. Dr. O'Meara, will you please come over here.

You have been up here so many times before, and tried to say 40 and 50 per cent and never got them right—why, it's been years and years! But for many years Dr. O'Merea has fulfilled that position. Dr. O'Meara said he would be glad to come to the House today if he had a suitable badge. It is certainly against the rules of the Michigan State Medical Society to have anyone who is not strictly a delegate, here; however, we have arranged for a suitable badge.

Dr. O'Meara is going to tell us what a quorum consists of.

J. J. O'MEARA, M.D. (Jackson): Mr. Speaker, I am J. J. O'Meara of Jackson, the ex-Chairman of your Credentials Committee. I have here in my hand the names of fifty-odd delegates who are represented in this room. This of course consists of a quorum, 50 per cent of whom aren't from any County. Mr. Chairman, you may now proceed with your meeting, and it will be legal.

Thank you.

W. S. STINSON, M.D. (Bay-Arenac-Iosco): Mr. Speaker, Dr. Cummings has the greatest number of ballots and Dr. Texter is second. Dr. Cummings and Dr. Texter therefore are selected for your alternate delegates.

THE SPEAKER: The Chair will then declare that Dr. Cummings and Dr. Texter have been elected as alternate delegates to the American Medical Association for a two-year term.

The next order of business is the election of an alternate delegate to fill the one-year unexpired term.

R. L. NOVY, M.D.: Mr. Speaker, I would like to place in nomination a man who is energetic, capable, able to think, able to express himself, and who can express himself in very sharp, short terms. I also have in mind a general who did not care to run for President, but if drafted and forced to do so would serve his country.

I place in nomination the name of Dr. Ralph Johnson, and therewith request that he be drafted.

THE SPEAKER: Ralph Johnson has been nominated. Are there any other nominations.

R. S. BREAKEY, M.D.: I should like the privilege of seconding the nomination of Dr. Johnson.

E. G. KREIG, M.D. (Wayne): I should like to move that nominations be closed.

The motion was severally seconded, was put to a vote, and was carried.

THE SPEAKER: The Chair will instruct the Secretary to cast the ballot for Dr. Johnson. Will Dr. Johnson please come to the platform? Dr. Johnson is a master of the English language, but for once we are not going to ask him to say anything.

XIV—e. ELECTION OF PRESIDENT-ELECT

The next order of business is the election of a President-elect. The Chair will declare nominations open for the office of President-elect.

ARCH WALLS, M.D.: Mr. Speaker and members of the House of Delegates, it is indeed a pleasure and a privilege to introduce a man who perhaps needs no introduction to any of you, but who can fulfill the qualifications for the Presidency of the Michigan State Medical Society.

This office requires many qualifications of that individual. This man, I am sure, can fulfill all of those qualifications. He has been active in organized medicine for over thirteen years. He was elected Secretary of our County Medical Society about thirteen years ago. From there he was elected President of the County Society. Then he was elected to the Board of Trustees, which he served for five years. From there he was elected as Councilor to your State Medical Society, which he has served and served well for the remainder of those years.

This office gives high honor to that man. I feel he is deserving of that high honor. He has the integrity that we expect of our President of the Michigan State Medical Society. He also has the ability to carry out the duties which are imposed upon that individual.

Without further remarks I wish to present the name of Dr. Clarence E. Umphrey for your next President-elect of the Michigan State Medical Society.

THE SPEAKER: Dr. Clarence Umphrey has been nominated to the position of President-elect. Are there other nominations?

C. K. STROUP, M.D.: I would like to second the nomination of Dr. Clarence E. Umphrey.

THE SPEAKER: Are there any other nominations?

R. W. TEED, M.D.: I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. Umphrey.

The motion was severally seconded, was put to a vote, and was carried.

THE SPEAKER: The Chair will appoint Dr. Candler and Dr. Breakey to bring the President-elect to the platform. Gentlemen, your President-elect!

(The audience arose and applauded.)

C. E. UMPHREY, M.D.: Tonight I wish to thank you for the great honor that you have conferred upon me. At the same time I am fully aware of the duties that you have conferred upon me. I would like to speak for just a moment about the element of chance in this particular office.

Had one of our members (who was beloved of all of us) lived, he would have been here in my stead. Had either one of two men been mentioned, one of them would have been here in my stead. In this great office there is still a great element of chance.

When I say that I am aware of the responsibilities, I believe I know whereof I speak. Someone said, "Are you afraid of those responsibilities?" I am not, and I'll tell you why: I have been with this organization long enough to know your executive office. I know Mr. Burns and I know the group he has surrounded himself with in that office. I am proud that he is with us and on our side.

I know your Secretary. I know the work he is capable of doing, and I know he has had many offers from other organizations. I am glad that he is on our side.

In your new C.A.P. program I know Mr. Brenneman, and for the committee who selected him I have nothing but praise. Have they selected a good program? I don't know; do you? I feel it is a good program. Many improvements have been installed and many more will be added.

In that connection, I also feel that the American Medical Association has an excellent program which should be supported by all of us. I know the members of The Council, and I wish to say to you now that any officer you select may have ideas, but when they get through advising him those ideas are usually pretty good; so don't you worry too much.

There are going to be many problems brought to us for consideration and discussion. They are going to need a lot of thought, and if you do not give us your thought, you are to blame. Your thought and your help has been solicited. About one year from now I will be supposed to submit a list of committees. Let's suggest some new names for those committees. Let's use the old guard in an advisory capacity.

If you will do those things, then again I wish to thank you, and I have no trepidation for what is ahead of me.

XIV—f. SPEAKER OF HOUSE OF DELEGATES

THE SPEAKER: The Chair will now open nominations for the position of Speaker of the House of Delegates. Nominations are now open for the position of Speaker of the House of Delegates.

H. A. FURLONG, M.D.: Mr. Speaker and members of the House of Delegates, it is an honor and a privilege for the Oakland County delegation to place in nomination for the office of Speaker of the House of Delegates one of its most respected members.

Perhaps first of all we should express our appreciation to Bay County for having sent our colleague to Oakland County twenty-nine years ago, for it was in Bay County that he was sired, educated and, under the tutelage of his physician father, took up the responsibilities of a practitioner of our profession.

He had a good start in the work that he has done for organized medicine, because in 1919, thirty years ago, his father was President of the Michigan State Medical Society. During the twenty-nine years he has been with us in Oakland County he has held every position that our County Society could give him. He was President in 1932. He has always been active in all those things that have had to do with the welfare of organized medicine locally.

We have come to look upon his work as a staff member of our hospitals as very valuable. We have turned to him constantly for advice and leadership.

He has been a delegate to this House of Delegates intermittently since 1924. For seven years he has been on the Board of Directors of Michigan Medical Service, and for the past three years he has been ably serving this House as Vice Speaker.

Therefore, it is with a great deal of pleasure, and with honor to our own County Society, that we place in nomination for Speaker of the House of Delegates, Dr. Robert Baker.

THE SPEAKER: Dr. Robert Baker has been nominated.

M. A. DARLING, M.D. (Wayne): I would like the pleasure of seconding the nomination of Dr. Baker.

THE SPEAKER: Are there any other nominations for the position of Speaker of the House?

S. L. LOUPEE, M.D.: Mr. Speaker, I move that nominations be closed.

GROVER C. PENBERTHY, M.D.: Second the motion.

The motion was put to a vote and was carried.

THE SPEAKER: The Chair will direct the Secretary to cast a ballot for Dr. Robert Baker as Speaker of the House. He is elected unanimously. Dr. Baker, I should like to shake your hand.

I should also like to pin on Dr. Baker this very beautiful speaker's badge about which I have worried for three years. Dr. Baker says he will make plenty of speeches next year.

Before we finish, there are three very important gentlemen in this group who also have represented us and will represent us at the American Medical Association. I should like to call to the platform Dr. Barrett, Dr. Penberthy and Dr. Huron, who are our other three delegates to the AMA. Gentlemen, will you come up and sit with us?

You know, when I started inviting notables up here I had no idea how many there were!

XIV—g. VICE SPEAKER OF HOUSE OF DELEGATES

The next order on the agenda is the election of a Vice Speaker of the House of Delegates. The Chair will declare nominations in order for Vice Speaker.

J. J. LIGHTBODY, M.D.: Mr. Speaker and members of the House, I would like to place in nomination as Vice Speaker of the House of Delegates one of the relatively young men of the House. He has been a delegate from Genesee County for the past four years. He is a graduate of the University of Iowa, but he didn't bring very much of the corn with him.

He is a radiologist, but he probably will outlive that. He was Editor of the *Genesee County Bulletin* for several years, and he is very well qualified for this position. He has been on several committees during the State meetings, and during the year has been on the Public Relations Committee and on the Industrial Health Committee.

I would like to place in nomination as Vice Speaker of the House of Delegates the name of Dr. J. E. Livesay, of Genessee County.

THE SPEAKER: Dr. Livesay has been nominated. Are there any other nominations?

F. W. BASKE, M.D.: I would like the privilege of seconding the nomination of Dr. Livesay.

R. W. TEED, M.D.: I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. Livesay.

The motion was severally seconded, was put to a vote, and was carried.

THE SPEAKER: The Secretary is instructed to cast the unanimous ballot for Dr. Livesay of Genesee County. Dr. Livesay, will you come up?

Dr. Livesay says "Thank you." We will hear from him probably for many years.

XIV—h. COUNCILOR 1st DISTRICT

Due to the election of Dr. Umphrey as President-elect, we now have one Councilorship in Wayne County that is open—the First District. It is for an unexpired term of two years. The Chair will declare nominations open to fill the vacancy of two years' unexpired term of Dr. Umphrey. Nominations are now in order.

F. A. WEISER, M.D. (Wayne): I am not going to give you a long rigamarole about this gentleman. He is a good friend of mine and a good friend of yours. He is a urologist, the Chief of Urology

at Grace Hospital. He is on the urological staff of Wayne University, and, more important than that, he was Chairman of the Public Relations Committee of the State Medical Society.

I would like to place in nomination Dr. L. W. Hull as Councilor of the First District for the unexpired term.

THE SPEAKER: Are there any other nominations?

G. C. PENBERTHY, M.D.: Mr. Speaker, I move that nominations be closed.

R. V. WALKER, M.D.: Second the motion.

The motion was put to a vote and was carried.

THE SPEAKER: Dr. Hull, will you try to find a chair up here?

Gentlemen, I believe our session is about to close. Certain recognitions should be made.

Dr. Foster has reminded me that Elmer C. Texter, M.D., the President of the American Academy of General Practice and our alternate delegate, is still sitting back there with ordinary people. Dr. Texter, you'd better come up here quickly!

E. C. TEXTER, M.D.: I still want to be "ordinary."

XVI. THANKS OF SPEAKER DE TAR

THE SPEAKER: Gentlemen, I want to start this accolade with a recognition of the services of our Secretary. Dr. L. F. Foster has given an amount of time which is simply inconceivable this year and last year to the average man practicing medicine. Most of us simply can't see how he can do it and carry on the size of practice he does.

I think recognition should go to the Chairman of our Council, Dr. Otto O. Beck. He puts in a tremendous amount of time to that work. You will notice that this evening, in calling our various luminaries to the stage, I have centered on the Past Speakers of the House of Delegates and our representatives to the American Medical Association. I purposely left out the President and the President-elect because, after all, their night is tomorrow night—but I think we should give them a hand.

(The audience arose and applauded.)

THE SPEAKER: Before we close I would like to mention the names of Bill Burns and Bob Roney, his assistant, and Hugh Brenneman and Russell Staudacher, his assistant. Without those gentlemen the executive office simply could not have run. We have the finest Executive Director and the finest public relations man in the United States, and when the executives from other areas come here they give us this recognition.

I don't think we should leave out of recognition three women who do a great deal of our work—in fact, all of our work at the State Headquarters. Miss Schulte, who is on the platform; Miss Chapman, and Mrs. Betty Brown Linton. They do a tremendous amount of work and have done so for many years.

We have a new Councilor whom I don't believe we have introduced, Dr. H. B. Zemmer of Lapeer, who has been appointed to fill the unexpired term of Dr. DeGurse.

I would like to thank the chairmen of the reference committees this year, and all the men who worked on those committees, because they did a tremendous job. You will note that the work of the House of Delegates this year went along with fairly good dispatch. It is due to the work done in those committees.

This is my swan song, my last chance at you gentlemen. I would like to express to you my very, very sincere appreciation for the very splendid spirit of co-operation I have noted in my three years of service. There certainly has been a lack of any kind of obstructionism. I have failed to see what I heard I should look for—a difference of opinion between Wayne and our State, or the interests of Genesee, or the obstructionist tactics of Ingham. I was warned to be careful of Bob Breakey. He has been one of the finest supporters I have had, in his own inimitable way. I was told that Ed Spalding would hop up every few minutes with a parliamentary point. What he actually did was to come up here and help me out.

I haven't experienced any of the difficulties I had been warned about. If there has been any criticism, it has been constructive criticism. Dr. Breakey was the Chairman of the Resolutions Committee last year or the year before, and he was a tremendous help. Dr. Spalding has always been helping me out, either after the session or before the session or during the session. I hope the Speaker and the Vice Speaker will see fit to call on Dr. Spalding, because if they do they just won't go wrong.

I would like to thank some of the men who have helped me off the scenes: Dr. Barone and Dr. Ledwidge. I would like to thank men like Dr. Armstrong, who called my attention today to something that was an oversight. Those are all constructive criticisms, and I think it is that spirit of the House that makes this a progressive House.

Last of all, I would like to pay my unqualified respects to the one man in the House who, in my opinion in these three years of service, stands out in a unique position. He espouses the unpopular causes; he has vision beyond most of us; he had the vision of Michigan Medical Service. He has constructive planning, he has imagination probably ten years ahead of his time, and I would like to take my hat off to Dr. Ralph Pino.

Now, gentlemen, I want to thank you and say goodbye. I want to bid you adieu. I hope you will give your new Speaker and your new Vice Speaker the same support you have given me in the work of the Michigan State Medical Society. Thank you.

XVII. COMMISSION ON HEALING ARTS

The House discussed one matter in Executive Session and instructed The Council to appoint a Commission on Healing Arts.

XVIII. ADJOURNMENT

The meeting was adjourned *sine die* at ten o'clock.

SICKLE-CELL ANEMIA

(Continued from Page 1486)

which depends on the inability of females with sickle-cell anemia to become pregnant and deliver live children who will survive. On the other hand, if a male and female with sickle-cell trait mate, it is quite likely that from this union will come a child with sickle-cell anemia.

Recently Neel (1949) has presented evidence in support of the hypothesis that sickle-cell anemia is due to the homozygous conditions for a gene which, when heterozygous, produces the sickle-cell trait. The kindred to which this patient belongs has been studied rather extensively by Neel in connection with the above-mentioned investigation, and the hematological findings will be presented in detail elsewhere.

This case further illustrates the futility of removing the spleen in cases of sickle-cell anemia. Splenectomy in this case had no effect either on the anemia or on the tendency towards sickling.

Other forms of therapy directed toward the stimulation of blood formation, such as liver extract, iron preparations, choline dihydrogen citrate, and high protein diets, apparently have little or no effect on the course of sickle-cell anemia. Whole blood transfusion is apparently the treatment of choice.

Summary and Conclusion

The twenty-fifth published case of sickle-cell anemia complicated by pregnancy is reported.

A family tree with studies for sickle-cell anemia and sickle-cell trait is presented.

It is suggested that eventually sickle-cell anemia may be bred out of the Negro race because of the inability of Negro females with sickle-cell anemia to become pregnant and deliver live children.

Splenectomy, iron preparations, liver extract and other stimulants toward blood forming are of no value in the treatment of sickle-cell anemia. Blood transfusion is the best form of supportive therapy.

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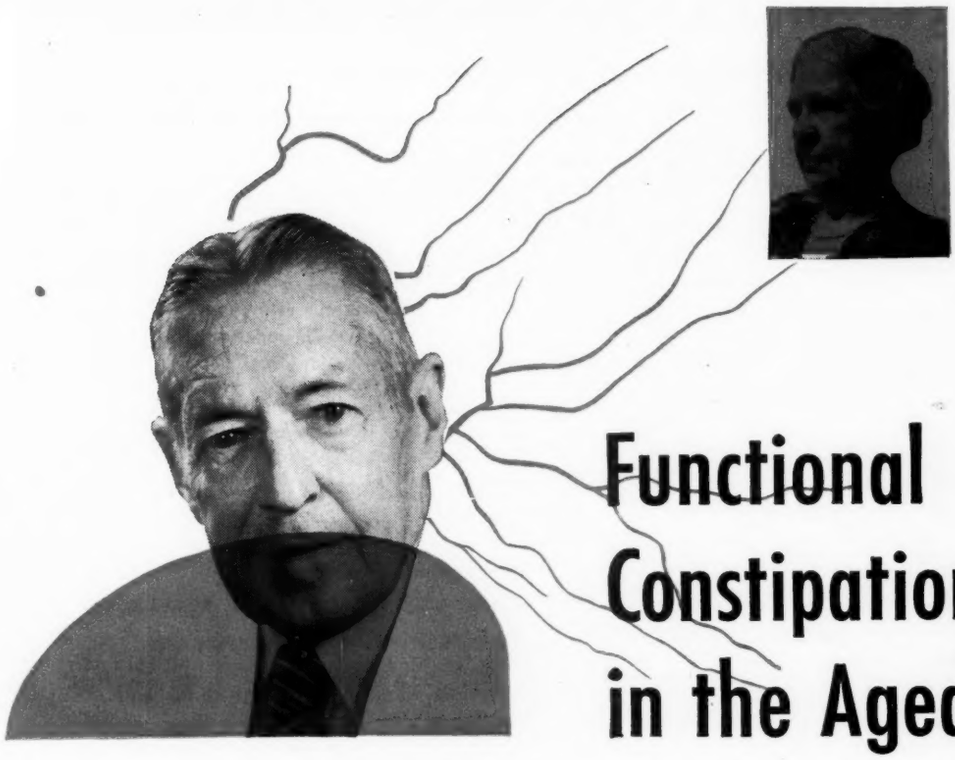

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*Werner, A. A.: The Climacteric in Women and Men, Postgrad. Med. 4:102 (Aug.) 1948.

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RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

TUBERCULOSIS X-RAY SURVEY

Mobile chest x-ray units of the Michigan Department of Health, offering free chest x-rays at thirty-two Michigan fairs and festivals this summer and fall, discovered 485 suspect cases of tuberculosis which otherwise might have gone undetected.

One suspect case was found for every 107 persons x-rayed. A total of 51,724 persons were x-rayed at the fairs and festivals. Of these 1,318 had abnormal chests. About two-thirds of these abnormalities were due to conditions other than tuberculosis—heart disease, pneumonia, silicosis, neoplasms and bone abnormalities.

A summary of the fairs surveyed in 1949 is shown in the accompanying table.

SUMMARY OF FAIRS SURVEYED—1949

County Fairs	*Total number x-rayed*	*Number with chest abnormalities*	*Number with reinfection tuberculosis*
Allegan County Fair, Allegan	4,168	57	27
Alpena County Fair, Alpena	2,157	64	16
Arenac County Fair, Standish	801	44	6
Barry County Fair, Bay City	1,386	43	8
Bay County Fair, Bay City	1,440	40	13
Blue Water Festival, Port Huron	1,617	46	26
Branch County Fair, Coldwater	2,828	67	17
Cass County Fair, Cassopolis	744	16	8
Clare County Fair, Harrison	800	8	6
Eaton County Fair, Charlotte	1,432	33	11
Gladwin County Fair, Gladwin	925	23	6
Hillsdale County Fair, Hillsdale	1,415	75	13
Iosco County Fair, Hale	1,002	23	15
Isabella County Fair, Mt. Pleasant	1,744	52	18
Jackson County Fair, Jackson	3,029	79	30
Lenawee County Fair, Adrian	2,937	75	27
Marine City Mardi Gras, Marine City	522	12	8
Mecosta County Fair, Big Rapids	867	54	9
Michigan State Fair, Detroit	3,417	74	42
Midland County Fair, Midland	2,468	41	14
Monroe County Fair, Monroe	1,349	50	17
Northern Michigan Fair, Cheboygan	1,018	27	10
Oceana County Fair, Hart	1,183	30	11
Ogemaw County Fair, West Branch	1,172	21	10
Ottawa County Fair, Hudsonville	555	8	5
Saginaw County Fair, Saginaw	2,357	63	25
St. Joseph County Fair, Centreville	1,086	40	16
Sanilac County Fair, Sandusky	1,088	33	10
Shiawassee County Fair, Corunna	1,120	28	13
Upper Peninsula State Fair, Escanaba	2,667	48	26
Western Michigan Fair, Ludington	2,106	30	18
Wexford County Fair, Cadillac	324	14	4
TOTAL	51,724	1,318	485

* * *

The Division of Industrial Health is testing x-ray equipment in the eleven state hospitals to assure that no radiation hazards exist.

* * *

The Michigan Department of Health has received report of house-to-house pamphlet salesmen who say that they represent the Department. The Department has no house-to-house or other salesmen. Those representing themselves as salesmen for the Department should be reported to the local health department or State Health Department at once.

The United States Children's Bureau now has reprinted reports of a series of surveys of the nutritional status of children in Michigan institutions which were conducted by the Research Laboratories of the Children's Fund of Michigan. The reports were originally published in the Journal of the American Dietetic Association (1948). The reprints are available from the United States Children's Bureau, Washington, D. C.

* * *

Through the co-operation of the local health departments in the Michigan Vision Conservation Program, the sight of more than 67,000 Michigan school children was tested last year. One out of every five had some vision defect.

* * *

Judging from figures prepared by the United States Public Health Service, there are probably 640,000 Michigan people infected with Brucellosis and about 6,400 of these are clinically ill of the disease.

How few of these people know they are ill or have been to their physicians for examination is shown by the fact that only 163 cases of the disease have been reported so far this year and only 998 cases have been reported in the past five years.

* * *

Three out of every 100 Michigan school children have some degree of hearing loss which needs attention, according to results of a six-year study conducted by the Hearing Conservation Program carried on by local health departments and the Michigan Department of Health. Of the 325,000 children whose hearing has been tested in the past six years, 3 per cent showed hearing loss and were advised to see their physicians. Of those who received medical treatment, 75 per cent improved, 50 per cent of these to normal hearing.

* * *

Russell L. Johnson has been named Division Engineer in charge of the Northern Peninsula office of the Michigan Department of Health. In addition to his duties as sanitary engineer, Mr. Johnson will represent the Michigan Department of Health in the peninsula.

* * *

Office nurses and other nurses who wish to become better acquainted with the services of the Michigan Rapid Treatment Center, Ann Arbor, may be given two- or three-day observation periods in the Center. Requests should be made through the local health department or to the Michigan Department of Health.

Planned by the Section of Nursing and the Division of Venereal Disease Control, the observation period for nurses provides an opportunity to become familiar with the Center, its personnel, its routine in examination, treatment and education. It also gives an opportunity

(Continued on Page 1534)

(Continued from Page 1532)

to sit in on contact interviews and to discuss problems of local follow-up.

* * *

The Division of Disease Control on October 28, 1949, received the report of a case of poliomyelitis in Dearborn on October 25, 1939. The report, sent by a Dearborn physician, was addressed to the Michigan Poliomyelitis Commission.

* * *

Dr. Alexander M. Campbell, former obstetrical consultant with the Michigan Department of Health who resigned in August, 1949, has resumed private practice in gynecology and obstetrics in Grand Rapids.

* * *

The well-known "Pierre the Pelican Series" of letters on good principles of mental health in child care are being sent to all parents of first born children in a limited number of Michigan counties through the co-operation of the local health departments and the Michigan Department of Mental Health. The letters consist of twelve leaflets prepared by the Louisiana Society for Mental Health designed to be sent to parents, one a month, during the first year of the child's life.

* * *

The Michigan Department of Health has received a grant of $38,360.00 from the National Foundation of Infantile Paralysis under which the Division of Laboratories will investigate the role of hypertonic solutions in the treatment of poliomyelitis in monkeys.

* * *

October visitors in the Department included public health people from India and Colombia.

Mohamed Sayed Ahmeed, Chief Administrator, Chest Disease Section, Ministry of Health, Cairo, Egypt, visited the Division of Tuberculosis and Venereal Disease Control.

Carlos Gomez, M.D., of Bogota, Colombia, a former student in the Department Laboratories, revisited the Laboratories before leaving for his native country.

* * *

DETROIT PHYSIOLOGICAL SOCIETY

(Continued from Page 1491)

eral vasomotor collapse occasionally encountered in the cirrhotic patient following the two rapid removal of ascitic fluid. Also, the increased quantities of circulating albumin following the paracenteses suggests that this protein or its immediate precursors is stored despite the presence of severe liver damage. Changes in the concentrations of the various serum proteins indicate that they should not be used for prognostic implications when obtained on the same day following the removal of ascitic fluid.

Communications

Wilfrid Haughey, M.D.
Editor, JOURNAL MSMS

Eloise, Michigan
October 26, 1949

Dear Doctor Haughey:

This is to notify you of the first annual meeting of the Frederick A. Coller Surgical Society, which was held at the University Club, Chicago, October 19. This society is composed of former residents of Doctor Frederick A. Coller, Professor of Surgery, at University of Michigan. Fifty-nine former residents of Doctor Coller were present. The society contributes funds annually to Doctor Coller to provide for a traveling fellowship for residents of his department. The next meeting will be held in Boston during the annual session of the American College of Surgeons.

DARRELL A. CAMPBELL, M.D.
Surgical Director
Wayne County General Hospital
Eloise, Michigan

* * *

Wilfrid Haughey, M.D.
Editor, JOURNAL MSMS

New York, N. Y.
October 21, 1949

Dear Dr. Haughey:

Through the years, summer in the United States always has been marked by outbreaks of infantile paralysis. And every winter we have come to expect a successful fund-raising campaign to meet the needs of those affected.

The March of Dimes campaign, enthusiastically supported by magazines as well as by the press and radio in the past, has always raised enough to take care of the polio situation. In 1949, for example, although fewer than a hundred persons contributed more than a thousand dollars, the money rolled in . . . dimes from the millions, your readers!

However, this summer saw more than outbreaks of polio. There was widespread, nationwide epidemic, with more cases than ever before in our history. All resources of the National Foundation for Infantile Paralysis were pressed into service. The organization's epidemic treasury was emptied.

Now the bills for the epidemic's aftermath pile up—bills for the treatment of the crippled, those still in hospitals, those who must be rehabilitated, bills to be paid without curtailing the training of medical personnel and scientific research to find a preventive. But funds to pay all of these bills are lacking. And we have no way of knowing how many more cases there will be next year.

We face a possible crisis in polio that will menace every man, woman and child in the United States, unless, this winter, the March of Dimes takes in more money than ever before. Your readers must know the need. That is why I ask that you call the situation to your readers' attention.

The Editorial Committee of your National Association

(Continued on Page 1538)

(Continued from Page 1536)

of Magazine Publishers has endorsed the 1950 March of Dimes. Won't you please remind your readers of the March of Dimes, if you can, somewhere in the issue you expect to circulate during the last two weeks of January, 1950?

Sincerely,
BASIL O'CONNOR
President, National Foundation for Infantile Paralysis

* * *

New York, N. Y.
November 4, 1949

To the Editor:

There have been many inquiries recently regarding the arrangements for covering the cost of care for poliomyelitis patients. There are a number of factors which will be of interest to your readers.

During 1949 a poliomyelitis incidence of unprecendented size (more than 37,000 stricken since January 1) has put serious financial strain upon the National Foundation for Infantile Paralysis. For the first time in its eleven-year history it was necessary to conduct a Polio Epidemic Emergency Drive which although very helpful did not entirely meet current needs.

In its avowed purpose to lead, direct and unify the national fight against infantile paralysis the National Foundation undertook support of research and education, for in these areas lie the ultimate hope for eradication of poliomyelitis. These programs are not to be compromised in any way.

The greatest cost to the National Foundation, however, is payment for medical care to patients. It is urgent for all physicians to assist in the institution of measures which will reduce costs without prejudice to patients. The chief costs are for hospitalization. Many poliomyelitis patients are hospitalized when they can be cared for at home at a reduced cost.

Our experience in this year's epidemic which has spared virtually no part of the country suggests the following:

1. Abortive, nonparalytic and mildly paralytic poliomyelitis patients are being hospitalized in the mistaken idea that the stated period of isolation must be spent in the hospital.

2. Overly prolonged hospitalization is frequent. This is particularly true of the paralytic patient who has achieved maximum improvement from daily physical therapy. Home care with periodic office or clinic visits is then in order.

3. There still exists in some places a general attitude that poliomyelitis is a bizarre disease which only a few physicians can manage. This is not so. It is disturbing, for example, to find physicians leaning so heavily upon the guidance of physical therapists and nurses. The physician's assessment of the total patient is the best index in determining when a patient shall leave hospital to receive home, office or clinic care.

4. Patients hospitalized on general ward services are

(Continued on Page 1540)

(Continued from Page 1538)

not charged medical fees ordinarily. When patients are hospitalized on isolation wards for poliomyelitis, however, bills for medical fees are at times submitted. Payment is frequently made by the local chapters of the National Foundation whose treasuries are now generally depleted.

It is hoped that your readers will understand clearly how urgent is our need for co-operation from all practicing physicians in the matters mentioned above.

Sincerely yours,
HART E. VAN RIPER, M.D.
Medical Director, The National Foundation for Infantile Paralysis

* * *

Wilfrid Haughey, M.D.
Editor, JOURNAL MSMS
Battle Creek, Michigan

Manistee, Michigan
November 12, 1949

Dear Editor:

Enclosed find a copy of a letter I have just mailed regarding an article in your October Michigan State Medical Society JOURNAL.

Sincerely, yours,
SAMUEL OSBORN, M.D.

November 12, 1949

Mr. Ed Adams
Detroit *Free Press*

Dear Sir:

Having just read your misleading comment in the October Michigan State Medical Society JOURNAL, I am compelled to draw attention to your apparently intentional deletion of the other high costs of living today.

Why do you pick on medical and dental expenses when other fees and costs are so high, also? Which do you think is more important or essential to our way of life today—having a baby, or having the car bumped out and painted; having a few teeth extracted (others filled, etc.) or getting your auto engine tuned up with new spark plugs, points and other accessory parts? (Check these relative and nearly equal fees).

I don't know what your connection is with the *Free Press,* but anyone in the public eye and writing for public consumption should first of all try to tell the people the truth and more important, even, leave a truthful impression. In these times of expanding government expenditures (usually, of course, to influence the election results—and don't try to deny this) don't you think it is proper for you to help the public in its evaluation of big issues—such as Social Security, instead of doing as your letter indicates and just agreeing with the masses who, of course, are being led by greedy political aspirants to either power or money?

Why not admit that the dollar today isn't worth 50 cents of yesterday and when high medical costs are mentioned, why, instead of intimating that the only way out is by "Governmental Control," don't you suggest that the real solution is to elect some honest leaders for our City, County, State and Federal Governments and for them to begin balancing the budget and economizing so that we may again have a dollar that is worth 100 cents. It sounds like you are jumping on the well-known

(Continued on Page 1553)

. . . . . NEWS MEDICAL

Michigan Authors

C. J. D. Zarafonetis, M.D., Ann Arbor, published a paper, "Infectious Mononucleosis" in the *Journal-Lancet,* October, 1949.

Gerald D. Spero, M.D., Detroit, published a paper, "A New Shoestring Corneoscleral Suture," in *Archives of Ophthalmology,* 1949

* * *

Annual Session Echoes

E. C. Reifenstein, Jr., M.D., New York (Guest Essayist): "It was a pleasure for me to participate in the 84th Annual Session of the Michigan State Medical Society. The hospitality of your group leaves nothing to be desired. Thank you again for including me in the program."

John S. Lundy, M.D., Rochester, Minnesota (Guest Essayist): "I certainly enjoyed very much participating in the 84th Annual Session of the Michigan State Medical Society in Grand Rapids."

Nancy McKenna, National Foundation for Infantile Paralysis, New York (Scientific Exhibitor): "I am anxious to offer my praise for the excellent management of the MSMS Convention. Your idea on location of registration desk and meeting rooms and the traffic control system was most satisfactory. I enjoyed the experience and feel it was a most successful convention so far as we are concerned."

Alexander M. Campbell, M.D., Grand Rapids: "You put on a wonderful meeting in Grand Rapids. The program was timely, practical and scientific. It gives me pleasure to congratulate you on performing successfully on this difficult task requiring so many details."

* * *

The Dietrich Ambulance Service has recently expanded its services with the announcement that they have taken over the ownership and operation of the Oxygen Therapy business of the Medical Gas Division of Liquid Carbonic Corporation. Dietrich will now supply physicians and hospitals through the Wayne County area with oxygen tents and complete oxygen therapy equipment. Rentals available at any hour of the day or night by telephoning UNiversity 2-6531.

* * *

"Doctors' Outline—Manual of Rheumatic Fever" is the title of a booklet just released by the Rheumatic Fever Control Committee of the Michigan State Medical Society.

This Manual gives the essential points of diagnosis and management and contains a brief bibliography and a table of heart murmurs as well as therapeutic and functional classifications.

Copies of the Manual are available, without cost, upon request to MSMS Rheumatic Fever Control Committee, 2020 Olds Tower, Lansing 8.

* * *

Rheumatic Fever Control Center Chairmen, as appointed for the year 1949-50 by the county medical society in which the Center is located, are as follows (up to November 1, 1949):

Alpena	Harold Kessler, M.D.
Detroit	N. E. Clarke, M.D.
Grand Rapids	J. E. Webber, M.D.
Jackson	Frank Van Schoick, M.D.
Kalamazoo	H. S. Heersma, M.D.
Muskegon	DeVere R. Boyd, M.D.
Saginaw	David P. Gage, M.D.

* * *

E. A. Pillsbury, M.D. of Frankenmuth recently was honored by his community for 46 years' service in that area. Dr. Pillsbury came to Frankenmuth in July, 1903, and for many years was the city's only physician. During his long service in Frankenmuth, he delivered over 2500 babies.

Pillsbury Day was one of the biggest days in the history of Frankenmuth.

Congratulations, Dr. Pillsbury, on a well-deserved honor at the hands of your patients and friends!

* * *

E. C. Texter, M.D., Detroit, has been appointed Chairman of the Committee on Hotels for the fourth Annual Michigan Postgraduate Clinical Institute scheduled for the Book-Cadillac Hotel, Detroit, March 8-9-10, 1950.

The Press Relations Committee for the Postgraduate Institute is composed of *R. A. Johnson, M.D.,* Detroit, Chairman, *J. S. DeTar, M.D.,* Milan, *H. F. Dibble, M.D.,* Detroit, and *S. W. Donaldson, M.D.,* Ann Arbor.

P. L. Ledwidge, M.D., Detroit, is General Chairman of Arrangements.

* * *

The Michigan Allergy Society will meet on Wednesday, January 18, 1950, with the Detroit Pediatric Society.

The program is as follows:

6 P.M. Cocktails, Huyler's L'Aiglon (Fisher Bldg.).

7 P.M. Dinner, Huyler's L'Aiglon.

8:30 P.M. Jerome Glaser, M.D., Chief of Pediatric Allergy Clinic, Strong Memorial Hospital—Instructor in Pediatrics, University of Rochester School of Medicine

(Continued on Page 1544)

(Continued from Page 1542)

and Dentistry—"The Diagnosis of Allergic Manifestations in Infancy and Childhood."

For reservations, communicate with Homer A. Howes, M.D., Secretary, Michigan Allergy Society, 1515 David Whitney Bldg., Detroit 26, Michigan.

* * *

C. E. Umphrey, M.D., Detroit, President-Elect of the Michigan State Medical Society, has been selected General Chairman of Arrangements for the 1950 Annual Session of the Michigan State Medical Society to be held in Detroit on September 20-21-22, 1950.

Dr. Umphrey recently addressed the American Association of Physicians and Surgeons at its annual meeting held in Detroit on October 28. His subject was "Medicine, Legislation, Federal Security and Labor"; the MSMS President-Elect also spoke to the East Side Medical Society on November 3 on "The Place of the General Practitioner in the Michigan CAP Program"; he also addressed the Dearborn Medical Society on November 9, using as his subject "Your Part in the MSMS CAP Program."

* * *

U. of M. Library.—A renewed invitation for all Michigan doctors of medicine to use the facilities available at the University of Michigan General Library has been received from Warner G. Rice, Director, and Sue Bietham Chief Medical Librarian.

The invitation has been repeated after consultation with H. H. Cummings, M.D., head of the Department of Postgraduate Medicine, Ann Arbor, who reports that "the University has a service adequate for the doctors of Michigan. Last year more than 400 Michigan doctors of medicine used the service with more than 1,000 volumes being loaned throughout the state."

Dr. Cummings added that "it seems entirely unnecessary for the Michigan State Medical Society to try and duplicate another medical library. It would take hundreds of thousands of dollars and years of work to duplicate what we already have in the University Medical Library. It may be that our doctors are not acquainted with the fact that the medical library is theirs and should be used by them."

* * *

Harry E. August, M.D., Detroit, has been appointed to the State Mental Health Commission by the Governor. Congratulations, Dr. August!

* * *

American College of Surgeons President F. A. Coller, M.D., of Ann Arbor conferred Fellowships on 923 initiates and five honorary Fellows at the ACS Clinical Congress in Chicago on October 21.

Michigan's Fellows included: James E. Bailey, Coldwater; Frederick W. Bald, Flint; Robert C. Bassett, Ann Arbor; Howard G. Benjamin, Grand Rapids; Duncan A. Cameron, Detroit; Daniel Carothers, Jr., Charlotte; Maynard M. Conrad, Kalamazoo; Paul F. Cooper, Kala-

(Continued on Page 1546)

(Continued from Page 1544)

mazoo; Cyril R. DeFever, Grosse Pointe; Reed O. Dingman, Ann Arbor; James A. Ferguson, Grand Rapids; John M. Hammer, Kalamazoo; Bradley M. Harris, Ypsilanti; Harry N. Jurow, Detroit; F. Bruce Kimball, Port Huron; Walter G. King, Ann Arbor; Emil J. Lauretti, Muskegon; Don Marshall, Kalamazoo; Henry T. E. Munson, Detroit; Michael R. Murphy, Cadillac; Charles H. O'Donnell, Dearborn; Edmund J. Robson, Lansing; Donald V. Sargent, Saginaw; Benton A. Schiff, Flint; Edward J. Shumaker, Detroit; Carl J. Sprunk, Detroit; Ethelbert Spurrier, Detroit; John W. Strayer, Niles; Christopher J. Stringer, Lansing; Leland L. Swenson, Muskegon; Clarence E. Umphrey, Detroit; Howard R. Williams, Ann Arbor.

* * *

Members appointed to the Michigan State Board of Registration in Medicine, as of October 1, 1949, were: E. W. Schnoor, M.D., Grand Rapids, and Luther Peck, M.D., Plymouth, both reappointments; new members included Howard H. McNeill, M.D., Pontiac; R. A. Sokolov, M.D., Detroit, and E. C. Swanson, M.D., Vassar. Terms are for five years each.

* * *

MSMS Council in Three-Day Session.—The Council of the Michigan State Medical Society will hold its Annual Session in Detroit on January 19, 20, 21, 1950. The eighteen District Councilors plus the President, President-Elect, Secretary, Treasurer, Speaker and Vice Speaker of the Society attend sessions of The Council.

A fourth day will be added to this sojourn in Detroit for attendance at the annual County Secretaries-Public Relations Conference, to be held at the Book-Cadillac Hotel, Detroit, on Sunday, January 22, 1950.

* * *

Alexander M. Campbell, M.D., Grand Rapids, resumed office practice as of October 1 in gynecology and obstetrics in the Metz Bldg of Grand Rapids.

* * *

The Indiana State Medical Association's House of Delegates, on September 29, 1949, voted to increase the annual dues in the Association from $15 to $35 as of January 1, 1950—the increase to provide funds to finance a state-wide public relations campaign against socialized medicine.

* * *

The recently organized United Cerebral Palsy Associations, Inc., has developed plans for a national cerebral palsy drive to be held in the spring of 1950. The budget for next year's drive totals one million thirty-four thousand dollars, to be used for training of personnel, research, expansion of treatment facilities, public education and community service.

* * *

A National Conference on Cardiovascular Diseases will be held January 18-20, 1950, at the Mayflower Hotel, Washington, D. C., under the sponsorship of the American Heart Association and the National Heart Institute.

(Continued on Page 1548)

(Continued from Page 1546)

Paul D. White, M.D., former President of the AHA, has been named Chairman of the Steering Committee of which Max R. Burnell, M.D., Detroit, is a member. The Conference will provide guideposts for a comprehensive and concrete program of action to correlate an all-out national attack on heart disease problems and will determine how professional and lay groups concerned with the heart diseases can best work together for the most effective use of their resources for the entire community.

* * *

W. G. Gamble, Jr., M.D., Bay City, has been appointed to the Michigan Tuberculosis Sanitorium Commission. Dr. Gamble was appointed to fill the unexpired term of Bruce H. Douglas, M.D., on September 16, and on October 9 the Governor reappointed him for the full term of three years.

* * *

The Annual County Secretaries-Public Relations Conference of the Michigan State Medical Society will be held at the Book-Cadillac Hotel on Sunday, January 22, 1950. Copy of the program will be sent to all county society officers and public relations committee chairmen.

* * *

The Genesee County Medical Society held its first meeting of the year on September 27, 1949 with the Buick Motor Division, General Motors, as its host. After

(Continued on Page 1550)

(Continued from Page 1548)

a tour of the factory by 120 physicians, a reception and dinner was held in the Buick Auditorium. The scientific address was given by Grover C. Penberthy, M.D., Detroit, on "The Surgeon and his Relations to the Employer and Employe."

* * *

E. C. Texter, M.D., Detroit, President of the American Academy of General Practice, addressed the American Association of Physicians and Surgeons at its annual session in Detroit, October 28. Dr. Texter's subject was "The Role of the General Practitioner Today."

* * *

Joseph M. Croman, Jr., M.D., of Mt. Clemens recently forwarded a pledge for $1,000 to the Michigan Foundation for Medical and Health Education, Inc. Dr. Croman's name has been added to the growing list of contributors to this fund, sponsored by the Michigan State Medical Society.

* * *

Horace Wray Porter, M.D., Jackson, spoke on "What's Wrong with Socialized Medicine?" at the annual BIE Day of Jackson, on October 27.

* * *

Nine hundred and fifty-seven applications for hospital projects now approved by United States. Up to October 1, a total of 957 project applications for federal aid under the Hill-Burton Hospital Construction Act have been approved by the Surgeon General of the USPHS. The recently approved congressional act (Public Law 380) will accelerate the federal-state expansion program at least 100%—this has been approved by President Truman. Leonard A. Scheele, M.D., Surgeon General, said special grants will be made to medical schools, regional hospital councils and other eligible applicants enabling them to add to their equipment, establish rotating internships, conduct refresher courses, provide for common utilization of facilities and adopt other measures designed to heighten efficiency of hospitals constructed with Hill-Burton aid.

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Correction—In the story entitled "Successful Cancer Conference" which appeared in the November JMSMS on page 1416, the name of A. A. Humphrey, M.D., Battle Creek, was inadvertently omitted as one of the speakers at the Conference held in Lansing on October 11.

Apologies, Dr. Humphrey!

* * *

The Inter-Association Committee on Health has been formed by six national associations: the American Medical Association, the American Dental Association, the American Hospital Association, the American Nurses Association, the American Public Health Association, and the American Public Welfare Association.

The Inter-Association Committee on Health will serve as a means for the exchange of information on the health programs of the participating organizations to the end that a common understanding is reached to cause a solution of national health problems. Activities contributing to the major objectives of improving the health of the nation will be carried out.

(Continued on Page 1554)

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

CLINICAL BIOCHEMISTRY. By Abraham Cantarow, M.D., Professor of Biochemistry, Jefferson Medical College, and Max Trumper, Ph.D., Commander, H(S)USNR, Lecturer in Clinical Biochemistry and Basic Science Co-ordinator, Naval Medical School, National Naval Medical Center. Four edition, 642 pages. Philadelphia: W. B. Saunders Company, 1949. Price $8.00.

The current edition of this book apparently records all of the important changes made in clinical biochemistry in the four years which have elapsed since the previous edition. Noteworthy additions are new or revised chapters on liver disease and functional tests associated with it, goitrogenic agents, and tests for adrenocortical function. A table of normal values inserted on the back fly leaf and cover is a convenient and valuable innovation.

This book should be in the library of any physician who practices thoughtful and scientific medicine. It is easy to read and is concise. It provides a correlation between clinical laboratory tests and disease processes so that it is of equal interest to the surgeon, pathologist, and internist. Much of the material cannot be found collectively in any other source. A.A.H.

* * *

FRACTURES. By Paul B. Magnuson, M.D., F.A.C.S. Professor of Bone and Joint Surgery and Chairman of the Department, Northwestern University Medical School; Attending Surgeon, Passavant Memorial Hospital and Wesley Memorial Hospital, Chicago and James K. Stack, A.B., M.D., F.A.C.S. Assistant Professor of Bone and Joint Surgery, Northwestern University Medical School; Attending Surgeon, Passavant Memorial Hospital and Cook County Hospital, Chicago. 323 Illustrations, Fifth edition, Philadelphia: J. B. Lippincott Co., 1949. Price, $12.00.

The purpose of the authors has been to supply a reference 'to meet the needs of the man who first sees the fracture." This purpose has been well accomplished in the new 5th Edition of "Fractures," by Magnuson and Stack. The early chapters cover fundamentals and bring out the importance of the knowledge of Physiology of bone repair, and the Pathology of Fractures is adequately covered. Traction and manipulative procedures are rightfully stressed over operative methods although in some instances the latter are described and the indications given. Each fracture is discussed individually and its treatment covered in an orderly and interesting manner.

The chapter on "Applied Anatomy of the Spinal Column and Spinal Cord" is an especially important one and although this is not discussed in great detail, it is concise and to the point. " 'Farmyard' Treatment of Fractures" is a most interesting chapter and should be of great value to those practicing in areas where hospital facilities are not readily available.

The treatise is well written, generously illustrated and fills a very definite need for those who are treating fractures. P.C.K.

* * *

THE PHYSICIAN'S BUSINESS. Practical and Economic Aspects of Medicine. George D. Wolf, M.D.; Assistant Clinical Professor of Otolaryngology, New York Medical College; Fellow New York Academy of Medicine; Fellow, American Medical Association. Foreword by Harold Rypins, A.B., M.D., F.A.C.S. Third edition. 96 Illustrations. Philadelphia, Montreal, London: J. B. Lippincott Company, 1949. Price, $10.00.

The author has gone to great length to outline the ambitions, prospects, plan of life and mode of existence of the practitioner of medicine. The book is rather large and all-inclusive, and makes an excellent guide for the practitioner who has been in practice long enough to afford this book. We think the contents are comprehensive and true, giving necessary information for the young medical student who is getting ready to enter practice and needs advice and counsel. However, the book is too big for that purpose, and too expensive. It should be on the reading desk of every medical class, but that distribution would be too small to pay. The book, in our estimation, should have been published in two volumes: One small volume covering the questions the medical student and young graduate are vitally interested in; places to locate; hospitals for internship; types of internship; specialization; medical careers outside of medicine. The other subjects are more suitable for the man who has had some experience. The advice is good. We think the advocated fees are rather high in many instances. How to get along with other M.D.s is most important. This is a good book, well written, but it will not be purchased by the young man who needs some of it most vitally.

* * *

AN ATLAS OF THE BLOOD AND BONE MARROW. By R. Philip Custer, M.D., Director, Laboratories of the Presbyterian Hospital, Philadelphia, Assistant Professor of Pathology, the University of Pennsylvania School of Medicine; Consultant to the Armed Forces Institute of Pathology. 321 pages, 285 illustrations, 42 in color. Philadelphia and London: W. B. Saunders Company, 1949. Price $15.00.

There is no book dealing with hematology which is exactly like this work either in illustration or treatment

of material. It rather pointedly ignores treatment except where it has some bearing on diagnosis and packs far more information in its unusual and excellent illustrations than it does in its text. The author, who has an excellent reputation as a pathologist, has presented an easily understood relationship between tissue sections and the hematological picture by well-chosen photomicrographs. The text suffers slightly from lack of uniformity in nomenclature although the writer has attempted to conform to recent changes. A.A.H.

* * *

NEW GOULD MEDICAL DICTIONARY. Editors: Harold Wellington Jones, M.D., Normand L. Koerr, M.D., and Arthur Osol, Ph.D.; First Edition, Illustrated. Philadelphia: The Blakiston Company. 1949. Price $8.50, $10.75 and $13.50.

The New Gould is almost completely rewritten, based on the needs of our present times. There are over a hundred contributors. New terms and changed usage of old terms are given in the book. New reference material is used. Table of Vitamins, enzymes, antibiotics, arteries, nerves are in a section by themselves. There are 252 illustrations, 129 in color. It is an entirely new treatment of a medical dictionary, and makes for intelligent and easy usage.

* * *

FUNDAMENTALS OF OTOLARYNGOLOGY. A Textbook of Ear, Nose and Throat Diseases: By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology, Director of Division of Otolaryngology, University of Minnesota Medical School, and Associates. 443 pages with 184 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $6.50.

Teaching of the undergraduate medical student is the foremost activation for this volume. It is beautifully prepared, very exact in its teachings, avoiding all controversial subjects, and giving numerous illustrations of the methods and means of diagnosis and treatment. It provides fundamental information to the physician, who is not a specialist, but who is called upon to manage many cases in the field of otolaryngology. It also contains much that the specialist can refer to readily and quickly. The chapter on vertigo, for instance, is absolutely up to the minute, giving the latest thought on these subjects. The same holds for most other branches. A valuable book for the busy man.

COMMUNICATIONS

(Continued from Page 1540)

gravy train like the other so-called "smart" people today. Just let the government take over and they'll settle the high cost of medical and dental care—sure, just like they settled the high cost of meat and potatoes and everything else they've got their hooks into.

You will find, I believe, that on the basis of income levels, hourly, daily, and weekly pay changes since before the last war that medical expenses have increased much less than other commodities and essentials of daily living.

Sincerely yours,
SAMUEL OSBORN, M.D.

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WANTED—Male child guidance psychiatrist for the Boys' Vocational School, Lansing, Michigan. Five years experience in the field necessary. Must have or be eligible for a license to practice medicine in Michigan. 40-hour week. Attractive salaries ranging from $505 to $605 a month. Permanent position offering civil service tenure and privileges. Send qualifications to Michigan Civil Service Commission, 220 North Grand Avenue, Lansing, Michigan.

WANTED—Director for one County Health Department located in north central Michigan. Population approximately 20,000. In reply state age and experience. Write to Wexford County Health Unit, Cochrane Building, Cadillac, Michigan.

THE MICHIGAN HEART ASSOCIATION

(Continued from Page 1497)

Program, a project which is essentially educational in its scope and which has been actively under way for several years. Other educational activities are under consideration and study.

The Michigan Heart Association contributes toward the financial support of the American Heart Association. Fifty per cent of its contribution is definitely earmarked for research, the benefits of which will accrue to the people of Michigan.

Future success in this important field of medical endeavor depends on active support by the citizens of Michigan and upon the active participation and interest of each individual member of the medical profession. W.B.C.

NEWS MEDICAL

(Continued from Page 1550)

Otolaryngologists and other members of the Michigan State Medical Society are cordially invited by J. M. Sutherland, M.D., Detroit, Vice President of the Middle Section of the American Laryngological, Rhinological and Otological Society, Inc., to attend a two-day combined meeting of the Middle and Southern Sections at the Peabody Hotel in Memphis, Tennessee, January 16-17, 1950. Speakers include Clarence W. Engler, M.D., Cleveland; Spencer Braden, M.D., Cleveland; John R. Lindsay, M.D., Chicago; J. M. Robinson, M.D., Houston; Theodore E. Walsh, M.D., St. Louis; Mercer G. Lynch, M.D., New Orleans; G. S. Fitz-Hugh, M.D., Charlottesville, Virginia; R. E. Semmes, M.D., Memphis; J. W. McLaurin, M.D., Baton Rouge, Louisiana, and Charles E. Kenney, M.D., Cleveland.

Index to Volume 48

AUTHOR'S INDEX

CONTRIBUTED PAPERS

A

T

U

V

DEPARTMENT INDEX

BON SECOURS HOSPITAL CLINIC DAY

CANCER COMMENT

COMMUNICATIONS

DETROIT PHYSIOLOGICAL SOCIETY

THE DOCTOR'S LIBRARY

EDITORIAL COMMENT

EDITORIALS

IN MEMORIAM

MICHIGAN'S DEPARTMENT OF HEALTH

MICHIGAN MEDICAL SERVICE

PUBLIC RELATIONS

SOCIALIZED MEDICINE

WOMAN'S AUXILIARY

YOU AND YOUR BUSINESS